COMMISSION TO ELIMINATE CHILD ABUSE AND NEGLECT FATALITIES

TAMPA, FLORIDA PUBLIC MEETING TRANSCRIPT
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Violence Prevention and Treatment Board, Michigan DHS; **Cheryl Polk**, Ph.D., President, HighScope Educational Research Foundation.

Chairman Dr. David Sanders: [00:10:00] Good morning. We're going to go ahead and get started. Welcome to the Commission to Eliminate Child Abuse and Neglect Fatalities hearing here in Michigan. And I'm David Sanders, Chair of the Commission. The 12-person Commission was created through the Protect Our Kids Act of 2012, and I think reflects the interest that Congress and the President have in this important issue. Our goal is to produce a report for Congress and the President that includes recommendations to bring the number of child abuse and neglect fatalities from over 1,500 a year today to zero. We're really here to learn from Michigan, and this is the third of our public hearings that we're holding across the country. We believe that many of the answers will be reflected in the testimony that we hear from states as well as the research that we'll hear about today, and are hoping that all of us take the opportunity to hear what is working and what is not working, and identify areas that we can collectively work to improve the plight of children who have been abused and neglected. I'm going to ask the Commissioners to introduce themselves, and we also have four Commissioners on the phone that I will identify, and then we will go ahead and get started. Commissioner Bevan.

Dr. Cassie Statuto Bevan:[00:11:32] Good morning, I'm Dr. Cassie Statuto Bevan and I'm very glad to see you all here and I hope you can all learn a lot because it is a really important topic.

Chairman Sanders: [00:11:47] Commissioner Cramer.

Robert Cramer: [00:11:48] Good morning. I'm Bud Cramer, Robert Cramer. I'm a former prosecutor from Huntsville, Alabama who really struggled in the early '80s to make sure that my front-line multidisciplinary team was working well together to provide that safety net for children.

Michael Petit: [00:12:07] I'm Michael Petit, the President of the Every Child Matters Education Fund in Washington D.C., a former Commissioner of the Maine Department of Human Services with responsibility for child welfare, and about a dozen years with the Child welfare League of America. So I'm very happy to be here in Michigan.

Chairman Sanders: [00:12:23] Commissioner Martin.

Hon. Patricia Martin: [00:12:24] Good morning, everyone. Thank you so much for being here this morning. My name is Patricia Martin. I'm the presiding judge of the Child Protection Division in Cooke County, Chicago, Illinois.

Susan Dreyfus: [00:12:35] Good morning, my name is Susan Dreyfus. I am the President and Chief Executive Officer of the National Alliance for Children and Families, former Secretary of the Washington State Department of Social and Health

Services, and Child welfare Director in the state of Wisconsin. I want to thank Director Corrigan for the weather. I was pleased to lead a task force here in the state of Michigan last year to help this state create a path forward for performance-based contracting in its child welfare system, and I will tell you that the snow here was coming from the bottom up and every which way every time we came in and left. So it's nice to be here on a nice day.

Amy Ayoub: [00:13:16] I'm Amy Ayoub from Las Vegas, a child advocate, and I look forward to hearing from all of you here. We need so much information to figure this horrible problem out, so thank you so much for everything you do and for being here.

Chairman Sanders: [00:13:32] And we also have Commissioners Marilyn Zimmerman, Wade Horn, Jennifer Rodriguez, and David Rubin joining us by telephone, and they will be able to make comments and ask questions of the panelists that are presenting. I'm going to ask the first two presenters, Nancy Vivoda and Justin McElwee, to please come up to the table up front and we'll get started in just a second. And I neglected to introduce myself, I'm David Sanders and I'm an Executive Vice President at Casey Family Programs and formerly Child welfare Director in two large urban areas.

So we're going to start with our presentations hearing from a youth and parent who have been involved in child welfare and who will provide us some initial comments.

And I will mention that all of the speakers have been briefed on both the content and timeframes, and we adhere closely to the timeframes because we want to make sure we have plenty of opportunity for Commissioners to ask questions.

So please proceed.

Nancy Vivoda: [00:14:36] Good morning, and welcome to Michigan. My name is Nancy Vivoda. I'm a birth mother of five children and a 1-year-old granddaughter. I'm from Detroit. I'm also a parent advocate committed to strengthening families and eliminating child fatalities due to child abuse and neglect. I'm pleased to be part of today's Commission hearing and will be submitting written testimony at the end of my presentation. I want to express my sincere thanks to Dr. Sanders and all of the Commissioners for providing me with the opportunity to speak with you today. I know that you will hear a lot of data and policy information today. I represent that data. I'm the face of that data. I'm here to talk to you about what I have learned from my own personal experience, and from working with hundreds of families and other parent advocates from all over Michigan, but also from across the country. You are all on an important mission, and I'm here to ask you to make sure that all children who are at risk are protected by taking the following action.

Focus on prevention. We cannot predict which kids will die, so we need to protect all children at risk. Invest funding and resources in strategies and policies that strengthen and support families, particularly families at risk. For example, the title IV-E waiver

allows child welfare systems to use funding more effectively to support families and keep children safely at home.

We need to fund services such as prevention and the Child Abuse Prevention and Treatment Act, CAPTA. Title II funding is consistently underfunded and needs significantly new resources. We should also utilize parents like me as parent partners to help other families avoid entering the child welfare system or to navigate the system if already involved. We need to include parent voices in every policy and practice decision and require this in funding policy statutes.

My introduction to the child welfare system was as a survivor of domestic violence. My family didn't need to be in the system. We could have received home-based family support services to help us with our crisis. I overcame many challenges while my children were placed in foster care. I had to learn how to navigate many systems with no introductions to them. I dealt with the trauma of separation, and I dealt with my children's trauma due to abuse in foster care. I worked to keep family traditions during weekly visits with my children. I wanted my children back more than anything. I was open to receiving support, collaborating with foster parents and caseworkers to complete my case plan as quickly as possible so I could be reunited with my children.

I was able to successfully reunite with my children in 2004 due to my resilience and other protective factors that I developed within myself and my family. Today I currently work as a parent advocate to help families navigate the system and provide support. I collaborate with social workers, parent advocates, and other professionals in various systems such as child welfare, the courts, schools, and many others. I work with various advisory groups and networks such as Casey Family Programs, Birth Parent Advisory Committee, Birth Parent National Network, and Communities of Hope initiatives. In fact, with my colleagues at the BPAC, we have created a document with some recommendations related to child welfare and we have shared that information with you today. We have learned that high-quality programs and effective policies require the voices of parents as partners in all aspects of planning, implementation, oversight, and evaluation. Partnerships with parents are integral to promoting better outcomes for families and communities. For example, my question to you, why isn't there a parent in your Commission? In conclusion, I ask you to take action to make sure all children at risk are protected by helping their families build protective factors and stay intact, strong, and healthy. This is crucial to eliminate fatalities due to child abuse and neglect. Thank you for your time.

Chairman Sanders: [00:18:51] Thank you. I think we will hear from our second presenter and then open up the questions to the Commission.

Justin McElwee: [00:19:01] Hi everyone. How are you doing today? Hopefully everyone is doing fine. Welcome to Michigan. I'm Justin McElwee. I'm a student at Michigan State University. I'm going into my junior year this year, and had my third

first day yesterday, it was great. I am studying International Relations at James Madison College. I agree with Nancy on prevention. We need to do more to prevent children entering foster care or the child welfare system. We could do this by adding more funding to preventing when caseworkers go into homes instead of removing children immediately, seeing what we can do for children that are not going or do not necessarily need to go into foster care.

I'm going to tell you a brief story about myself when I entered care to hopefully convey some of those ideas of what we could do to prevent more. I'm going to try and keep seven years in five minutes, hopefully. I came from a very large family. I had seven siblings, a two-parent household, and one of the problems was poverty. We are here to speak about eliminating child abuse and neglect, but as a country, as a wealthy country, we need to do more to eliminate poverty. But as we all know, that is not your job and that wasn't why the Commission to Eliminate Child Abuse and Neglect was created. So we have to do more when families are poor or when abuse and neglect are going on in the home to intervene, to put money up front so we can save money later on. Hopefully you spend less money because hopefully those costs are less than when a child enters care.

So I came into care at the age of 13. I remember we were very poor, but my parents did a very good job of taking care to make sure we'd get to school. And we were one day coming home and it wasn't an immediate thing, our condition wasn't critical, but I remember coming home with my siblings that day and entering foster care, and just thinking, "What went wrong?" Thinking, "Was it really that bad at that point?" And looking and reflecting back on it, yes, it was that bad. Our living condition was that bad. But just how our welfare system is set up, when we left the home my parents could do much less, have much less access to resources to meet some of those requirements, such as getting adequate housing to get us back. So at that point, there was nothing much more they could do at their age as in job training or getting more education, even if they did meet the requirements by the court. So moving on past that, I spent some years, or even moving into foster care I stayed with a relative and it was just the funding at the time in '08. We went through the very devastating recession, so when she took us in as a single foster mom taking in three kids was a hardship for her, and due to the lack of funding, I wasn't able to stay there. So after that I had moved on, and my behavior wasn't very well at the home either, but I think some of those stresses came from underfunding in the household and giving adequate funding to those foster parents. So I moved into another residential treatment, and as we all know that is very expensive in this country to have. And once again, if we had some of the necessary funding that was for prevention then we wouldn't have to spend those dollars there. So I spent about a year there and then moved on to another foster home. It was a pretty good foster home, more foster children, older couple that was married and did foster care for some years. I don't know if there was adequate funding at the foster home, but I moved on to another residential, and we had to spend more money there in my lifetime. So of the hundreds of thousands of dollars

that was spent for me in care and the $10,000 it would have taken to get my parents on their feet, that's a big disproportion as to what we could have done as a child welfare system up front.

So what I'm advocating for is more funding to prevention, more funding to maybe have some of those relationships with my parents now and to have tighter relationships with my siblings that I missed out on over those years being in residentials and not living with my siblings. So I just did an internship with Foster Love, which is the national organization that does a lot of advocacy on the national level for child welfare, and we work with Casey some. So some of these ideas have been thrown around, I've been hearing some of these ideas, and that's why I'm a big advocate of more funding up front than later on. Thank you for your time, Commissioners.

Chairman Sanders: [00:25:40] Thank you, Mr. McElwee. Are there any questions from Commissioners? Commissioner Ayoub.

Ayoub: [00:25:49] Ms. Vivoda, thank you so much for being here and thank you for all the work you do to help others maybe not go through the same challenges you did. Could you tell me where you found the greatest breakdown of communication between the agencies? You said you had a hard time navigating that. And also, you said that you help other people navigate. How do they find you?

Vivoda: [00:26:10] Thank you. The most challenging part was in the beginning of the removal. As a victim of domestic violence I never saw myself as the perpetrator or how I was part of that, and the protective service worker was more focused on the safety of the children, which she needed to, instead of guiding me or helping me understand the process. It went too fast for me. And then the court system and understanding how that looked like. I was very petrified of that system, and clueless on how to navigate it. And once my children were reunited and I became a parent advocate, a family advocate in my community, through their help with the department they funded the Parent Partner Program, who trained me to be a zealous advocate, and that's how families were referred to our program. And I've worked 24 hours with them, which was something that I didn't get, that emotional support that was so important while you're trying to get your children back.

Ayoub: [00:27:14] So how do they find you now? How does someone that needs to learn how to navigate it find you?

Vivoda: [00:27:16] The court makes referrals, as well as DHS.

Ayoub: [00:27:23] And do you feel that the agencies do communicate well, it's just sometimes people don't understand or it moves too fast, like you said?

Vivoda: [00:27:32] Absolutely. We're doing a much better job in communicating with families, and there are a lot of attempts from the department and the court system to

improve those areas. But the Parent Partner Program is an area that needs more funding. I wish that there would be parent partners that can help families on the prevention side, not just when kids enter the foster care system. If I had those services, my kids wouldn't have been in the foster care system. If someone would have said, "Hey, you're in a domestic violence situation, you need to move to China in order for your family to stay together," I would have done that instead of going around three months trying to figure out what is a "court order" and what does that look like?

Ayoub: [00:28:15] Thank you very much.

Chairman Sanders: [00:28:18] Commissioner Dreyfus.

Dreyfus: [00:28:20] Thank you very much. Ms. Vivoda, I wanted to ask you a couple of questions. So obviously we're trying to focus in on how to prevent children from dying from abuse and neglect, obviously very, very serious. And I'm wondering whether it's through your organization or through other similar organizations around the country that are working with birth parents to hear the voice of birth parents where there has been the experience of child fatality due to abuse and neglect within the family. To understand, from their perspective, what could have, should have, would have helped to have eliminated that tragedy from happening. And to hear that voice of birth parents, I think, would be very helpful to our work. So anything you can do in your work here in this state or as you are connected with other national, similar groups, as a Commission member I would really appreciate hearing that voice.

Vivoda: [00:29:00] Absolutely.

Dreyfus: [00:29:11] The second thing I want to ask you though is I was reading this vision for a better child welfare system, and about birth parents and their recommendations, and I'm specifically interested in the recommendations around child protective services. So we know we've got a child protective services system that oftentimes, by the time the phone call actually gets screened in, a lot has gone on. A lot has gone on prior to that. And yet there are recommendations that are made by this birth parent group about what could happen in child protective services that could potentially get us into homes earlier or more effectively, and one of the things you specifically raised, which I'm very intrigued with because I know this has happened down in some areas in Florida, where birth parents that have been trained like you go out with the CPS staff person. From the time of that knock on the door to reduce that adversarial nature and get parents to want to cooperate and work with the system so that children are not needing to be removed and those safety factors could be dealt with. So could you just say a little bit about child protective services, that knock on the door, those phone calls that come into intake, and what you think could happen to change that up to hopefully help us to, again, prevent children being in situations where they end up being killed by abuse and neglect.

Vivoda: [00:30:31] Absolutely. One of the things that we're working on now in our community is through the Communities of Hope initiative, which is creating hubs where families like myself can come and knock at the door before they even come to the attention of protective services. As we know, protective services has a horrible reputation in the communities of people that come and snatch their children, which is not true. So the fear there is to go and knock on protective services, "I need help. My utilities have been shut off because I got laid off," or for whatever reason. It's that educational piece that we need to have in the communities and through those community hubs. In the recommendations, as you read, that's our goal: to help reduce the number of children that are coming into the foster care system. But also, the other side of that is having services that don't require a court order, for example, in order to get a prevention service.

Dreyfus: [00:31:36] Thank you very much.

Chairman Sanders: [00:31:40] Any other questions from Commissioners?

Petit: [00:31:45] I have a question of Justin. Thank you for sharing your experience. Tell me, at the age of 13 when you were separated from your family, I think that's what you said, 13?

McElwee: [00:31:54] Yes.

Commissioner Petit: [00:31:57] Was there a sense of safety and danger for you at that young age? Were you conscious of that? Because you were concerned about, you said looking back, in retrospect you felt the conditions were as bad as they were. But what were you thinking about at the time that the state was coming in and separating the children from the family?

McElwee: [00:32:20] Well, at that time no one did a very good job of explaining anything, especially as a kid. People look at you as that way so they don't take the time and explain what is going on. But even at the age of 13, I mean you could tell. There's a breaking point where a child could tell their conditions are not like every other child, you know, even raised in a community that has a very high rate of poverty. But at that time you don't know what is going on. People tell you two or three months, it turns into five years of being removed from the household. And so honestly, I don't know. How can you tell, how do you know the kids that just don't belong in foster care and the ones that do belong in foster care? That's a very hard decision, because you could have looked at my case at the time and said, "Yeah, you do belong in foster care." But honestly, you ought to go back and say, "No he didn't." I mean I can't even make the distinction. So it's a very hard distinction to make.

Petit: [00:33:38] Thank you.

Chairman Sanders: [00:33:41] Any other questions from Commissioners? Well thank you very much. Very informative, thank you. I'm going to ask Commissioner Covington to introduce herself.

Commissioner Covington: [00:33:56] Good morning, and I'm sorry if I was late. My name is Teri Covington, I run the National Center for the Review and Prevention of Child Deaths, which is actually based here in Michigan at the Michigan Public Health Institute. And I look out and I see a lot of old friends, and I just want to say I'm really here in many ways because of the vision the state had in 1994 to invest a lot of resources back then, and they have continued to invest a lot of resources trying to understand why and how children die.

So I'm really honored to be here because of Michigan.

Chairman Sanders: [00:34:33] Thank you, and I'm going to ask the next panel to come up: Steve Yager, Dr. Bethany Mohr, Brian Hunter, Lora Weingarden, and Detective Elizabeth Reust. And as they are coming up, one of the charges from Congress is for us to better identify ways of counting the number of child abuse and neglect fatalities. All of us recognize that one fatality is one too many, but the national data source that is utilized today, which is called NCANDS, was actually found by Congress to be an undercount. And we've been hearing the challenges with actual identification of fatalities and the counting. And the reason that it is so critical is because for us to make recommendations on how to prevent fatalities, we need to have an understanding of both what the number is and what the definition is. So we want to hear from Michigan how this is going on, and again, each speaker has been briefed on both the time and content, and we'll adhere closely to the time. I don't want to have to cut anybody off, but we want to make sure there is plenty of time for the Commissioners to ask questions and make comments.

So we're starting with Steve Yager, I believe.

Steve Yager: [00:35:55] Good morning, Commission. It's an honor to present for this distinguished panel, and Commissioner Covington, it's good to see you again. We began this work in Michigan in 1994, and it's been a long but very pleasant journey.

My presentation will move quickly as I provide a high-level overview of the process and mechanics of tracking child deaths in Michigan. I will address definitions, the complaint process, data collection, fatality reporting, data improvements, gaps, and then I will close with some statistical information.

Michigan bases both its CPS case assignment and disposition on the Michigan Child Protection Law; we call it the CPL and its practice applications through CPS policy. Child abuse fatalities are fatalities that are a result of expected, intentional, incidental, and/or planned behavior on the part of a parent, caretaker, or person responsible for the child's health or welfare, or an action that a reasonable person

would expect to be a proximate cause of an injury resulting in a death to a child. Caretakers are expected to eliminate reasonable risks when they are able and have knowledge of a risk. All child death investigations are subject to Michigan's requirement for joint investigations between law enforcement, CPS, and other relevant parties. The determinations made by law enforcement and/or medical examiners are important factors in a CPS investigation; however, CPS makes an independent complaint disposition based on a preponderance of evidence.

Now I want to talk about the complaint process. Michigan implemented centralized intake in March of 2012. Centralized intake has provided greater consistency in policy application regarding case assignment decisions, and it has afforded us the opportunity to insert robust quality control measures. Central intake makes the final assignment decision for all complaints, even in child death complaints. Any sudden, unexplained infant death must be assigned for a full field investigation in Michigan. Prior to rejecting any complaint of a child death, regardless of age, a preliminary investigation must occur at a minimum consisting of a consultation with law enforcement, a review of lien and central registry, and a case file review, among other things. Even if the deceased child has no siblings, that is not a sufficient reason to reject the complaint in that the parent may have other children at risk that we might pick up in our Birth Match system, which you'll hear about later today.

When a decision is made to assign a child death case it is prioritized as an immediate response case and a joint investigation begins. Following the investigation, all child deaths by abuse or neglect are reported to NCANDS, and all child deaths are reported in our required annual CAPTA report.

We'll look at some of the data that we collect in Michigan. The department is very fortunate to have a strong and collaborative local and state child death review process, as I mentioned earlier, that began back in 1994 in Michigan. As a result of our collaborative system approach, DHS is able to collect comprehensive demographic information and data, including data points such as age, gender, race, domicile, household composition, and other factors. We also collect child-specific data like the location of the death, abuse and neglect dispositions, and trend information. Our collaborative approach also affords us the opportunity to collect child death data from our partners, such as death scene reenactment reports, police reports, and medical examiner reports. The data obtained by DHS from state and local groups, along with our SACWIS data system, will continue to support the data-driven approach to identifying abuse and neglect deaths and assessing and reducing child deaths through the use of information and predictive analytics.

Once our data is collected, it must be reported. Accurate reporting is critical, and we have implemented practices to ensure accuracy. Michigan NCANDS, and we've already heard about NCANDS this morning, is captured through the department's statewide automated child welfare information system we call MiSACWIS, which was

implemented in April of this year. Our new system will improve our ability to specifically link a child victim to abuse and neglect as the cause of death, and this will help improve our data integrity.

Before Michigan reports child death data to the Children's Bureau, we vet the data by using a number of internal reviews. Our Office of Family Advocate, which functions like an internal ombudsman, our foster care and CPS program office staff, our division of continuous quality improvement, and our data management unit all review information to ensure data integrity before we submit our federal file. The staff involved have significant policy and field experience and are experts in the field of CPS policy and practice.

Michigan is also very fortunate to have a contractual relationship with the Michigan Public Health Institute, we call MPHI. MPHI collects and organizes information from local child death review teams who use standardize CDC forms, they facilitate the state child death review team, as well as the CAPTA-required Citizen's Review Panel on Child Fatalities. The state child death review team provides an accounting of all child deaths and prepares an annual report for the legislature and the department. The state child death review and report is included in our annual required CAPTA report for reporting on all child deaths.

So how can we improve? Meaningful policy and practice change requires robust child death information. Child death information is greatly enhanced through focused attention on a collaborative approach to data collection. Good data allows us to isolate and address specific risk factors, such as the role of domestic violence, which we heard about earlier today, or substance abuse, or other issues in these cases. Michigan is actively seeking ways to utilize data from many sources, internal and external to the department. To move towards better data, Michigan is focusing on data sharing among partner entities, including law enforcement, the medical community, the courts, the Department of Community Health, the Department of Education, and the Office of Children's Ombudsman.

Nationally, we need clear and specific standards for data collection and reporting. Our state policy dictates which cases should be investigated, and how each case is to be dispositioned. Every state can have a different methodology for collecting and reporting numbers, preventing a meaningful comparison across states and limiting our ability to learn from each other. And I would be remiss if I did not mention that funding must support a collaborative approach to data collection. Lastly, Michigan data is improved by way of enhancements to our SACWIS system.

So are there gaps? Gaps and identification of abuse and neglect fatalities in Michigan exist primarily due to under-reporting. Sudden, unexplained infant deaths are not always reported to CPS. Similarly, suicides and neglect deaths are not always reported. Even when cases are reported, there are occasions where the report is not

timely, preventing an immediate death scene investigation and potentially compromising evidence collection and the CPS investigation. When CPS is not aware of a death, the case disposition might be solely based on law enforcement and medical examiner findings. Moreover, law enforcement might not be aware of pertinent information contained in a CPS file. In either case, CPS is prevented from reporting a death to NCANDS in that they were not involved. We are only able to respond to cases that come to our attention and for those that are reported, our response is robust.

This last slide shows some of Michigan's specific data, and as you can see, our numbers have not moved much over the past three years. Overall, we had about 1,220 per year. We receive about 345 complaints of child abuse and neglect deaths each year. We assign approximately 222 child death reports or complaints each year for a full investigation, and of those, approximately 79 per year we substantiate some form of abuse or neglect related to the case. And in 62 cases per year, on average, we substantiate abuse or neglect as the specific cause of death in a case. So as you can see, our trend data is fairly flat on all accounts, although we've seen some trending down in our NCANDS child deaths as a result of abuse and neglect.

Then lastly, we wanted to present a little bit of information on our trend deaths on foster care wards. As you can see on these striped bars, the overall graph deaths have remained fairly flat since 2010, averaging about 16 per year. The smaller graphs, the red bars represent child deaths, foster youths who died in care by the hands of a substitute caregiver. And thankfully those numbers are very low, and as you can see, since 2008, it's been at zero or 1 per year. That is still unacceptable. We do not want any child injured while in care of the department.

So that concludes my presentation, and I thank you for the opportunity to present today.

Chairman Sanders: [00:45:13] Thank you and we'll go through the panel presentations and then open up for questions. Thank you very much. Bethany Mohr.

Dr. Bethany Mohr: [00:45:20] Good morning, Commission. I am Bethany Mohr. I'm the Director of the child protection team at the University of Michigan, and I basically have a little bit more of a ground-level view of child death review. I was working in Florida previously and was on their state team and worked with some local teams and ran a local team, and now in Michigan I participate in two to three teams.

So one of the things that I would like to talk about a little bit is having a standardized approach to identify cases for review. So we do a tremendous job in Michigan through the MPHI. When I attend death review, sometimes I feel that there may not be as many cases as we could be reviewing. Sometimes we are not necessarily reviewing all cases in terms of motor vehicle collisions and situations in which there could be issues regarding neglect contributing to the death. And so I would really hope, and of course this has to do a lot with funding and people volunteering their time, but just again to

have more standardization with regard to making sure that we're actually reviewing all of these cases.

Also, one of the big issues that I have not only from a child fatality perspective but also from a child abuse and neglect perspective in general with children who have not died is the issue of neglect, which Steve talked about. And in looking at the NCANDS data, even though we show that neglect by far is the number one killer of children due to maltreatment, we still have a gross underestimation, in my opinion, with regard to the numbers.

One of the things that is really important to remember is that in order to actually keep appropriate numbers with regard to neglect is obviously identifying children who are victims of neglect. On the front lines, when children come into our hospital into the emergency department, even with a death sometimes we have no idea whether or not there was any neglect which contributed to that death. And sometimes, with unexpected death in older children, as Steve mentioned, we need to make a report to child protective services. And I will say that across the state I guarantee that doesn't always happen. So in order to actually get the information and to delve closer and more deeply into these cases, we're going to have to see if there was, as Steve said, intimate partner violence, drugs, and other things which contributed to the death. And we do a tremendous job, I feel, in Wayne County and also in our own county, in Washtenaw County where I work at the hospital, but obviously funding is needed in order to do more thorough scene investigations throughout the state. I strongly, strongly feel that every county in Michigan, all 83, should have some type of scene investigation capabilities. And I will be honest, I am not aware exactly what is happening throughout the state, but even if resources aren't available for extremely small counties, say in the Upper Peninsula, in Northern Michigan and Western Michigan, the hope is that maybe those counties can work together and have an investigation team who covers more than one county, obviously.

And the other thing that I wanted to talk about is ingestions, which also has to do with neglect. Often times, even before a child may come unfortunately into the hospital and have died or died on the scene due to an ingestion, many times we feel that things are accidents and label things as accidents, and ad nauseam at the hospital people...I probably am labeled as saying that my pet peeve is I cannot stand the word "accident." There are things that are truly accidents, but most things, with regard to injuries and fatalities with children, have to do with some element of neglect; not meaning that every neglect is the same and we're talking about egregious neglect in every case, but there is always an element, even in my own personal life with my own children. There is going to be times where there is some element of neglect, which I could have been a better parent, or watched or supervised in a better fashion. So ingestions are a big deal.

Also drownings, we oftentimes even have some debate within our institution about whether to file a report with CPS with regard to near drownings. So if we're not filing reports with regard to near drownings, we are potentially putting that child at risk for actually coming back later dead due to a drowning. And so I think that one of the things that we can do to help our numbers and to decrease the amount of deaths through prevention but also to get better counting is for people to realize and delve into even if something is not due to physical abuse, that we have to evaluate for neglect and not just stop and say, "Oh, the history makes sense," or "You know, this could happen to me," but to really delve into that neglect piece.

And so one of the last things I'd like to say is in terms of doing multidisciplinary investigations is that we always say this and it sort of seems like, "Oh, we know this," but it is so, so crucial for all of the parties to communicate. If we don't communicate, information that I may have is not related to CPS, is not related to the medical examiner … to be honest I wish that we had more communication with the medical examiner. I feel that although the medical examiner with the investigators and the ME's offices try to get as much information as they can, we may at the hospital have even more information that is not even in the medical record. Everything should be documented, but we all know that it's not perfect. So with that communication between physicians who actually were on the front lines in the emergency department, the MEs working with child abuse pediatricians and talking about other situations, our experience is in utilizing that. I just feel like a broader approach would definitely give us more information about prevention in the future.

Thank you very much.

Chairman Sanders: [00:51:20] Thank you. Brian Hunter.

Dr. Brian Hunter: [00:51:26] Hi, I'm Dr. Brian Hunter; I'm the Medical Examiner for Genesee County. I've been involved with MPHI at the state level of child death review and on multiple local child death review teams.

Just to give you a perspective on what it is that I do so that we're not left with what happens on television as an understanding, as the medical examiner my job is to determine the cause and manner of death in cases that fall under my jurisdiction. Typically these are deaths where the cause of death is unknown or suspected to be due to traumatic means.

Obviously, when children die, the great many fall into one of those two categories. There are obviously children who have long medical histories that don't fall into that category, but many childhood deaths fall into either the sudden, unexpected death or suspected traumatic death. When a call comes into our office it comes into our medical examiner investigators. My office is blessed to have investigators, and an investigation occurs. Hopefully that occurs in conjunction with law enforcement and CPS. I would like to say it always does, but that's not true. That investigation serves as

the history and background information that I need in the case evaluation. The investigation is done as soon as possible, right after the death. That information is brought to me the next day, and I review it prior to me doing an autopsy. Obviously, an autopsy is a post-mortem surgical procedure where I am doing an external examination and an internal examination. Again, the goal is to detect injuries and natural disease that may have related to the death. During that autopsy I'm drawing specimens and I'm sending them out. Most frequently it is toxicology, but in the cases of infant deaths I'm also sending out specimens to other laboratories, like microbiological cultures, etc. I gather all that information and put it together in a report. Hopefully, that report is as reflective as possible of everything that has gone on with the child, but that is highly dependent upon many of the factors that have already been presented. And that means it is dependent upon how well we have collaborated as a team.

Child abuse and neglect deaths occur on a continuum. At one end, on the left side, we have the egregious injuries, the cases that everyone agrees are horrible examples of child abuse, easily detected and everyone agrees. However, at the opposite end of the spectrum we have a large gray area, and if I think we're undercounting I think it is in that gray area, as my colleague just mentioned. In the neglect cases, in the very subtle abuse cases where the injuries don't necessarily link to the actual cause of death but they're not really well explained by a story the parents are presenting.

I think this continuum illustrates how we're having a problem in two areas; an area of consensus and an area of collaboration. In consensus, we don't all agree on what is neglect, or what is mild neglect, or what is severe neglect. Is not watching your child at a pool party and the child winds up at the bottom of the pool severe neglect or just an accident? Is sleeping with your child, sharing a sleep surface while breastfeeding and falling asleep severe neglect or an unfortunate accident? We lack consensus in defining what is neglect and even in extreme examples. I've done an autopsy on a child who really looks like a skeleton with skin on it. I mean it looks like an elderly person just shrunk down and they still were unable to prosecute because they could not come to consensus about whether the mom should have known better.

Collaboration. We're still operating in silos. I think everything that Mr. Yager presented was very true about how things can happen and in some places are happening regularly, but we're still deficient. The medical examiner doesn't have necessarily all the CPS information or the medical information prior to autopsy. CPS isn't necessarily willing to share records. We've encountered that in some places where they're not willing to share records in a timely fashion.

Law enforcement still isn't inviting CPS to the scene or they are letting them into the scene way after it has been altered and in a non-timely fashion. We're still operating in silos.

In the medical examiner world, we can improve by having resources to train investigators specifically in the area of childhood deaths. That requires special training. And there are many jurisdictions that still don't have dedicated, trained medical examiner investigators. So having the resources to train them through well-accepted, standardized training programs is probably one of our biggest deficiencies, and making sure that all the counties have those resources. There are counties that are small that don't have the funding they need to do that. So encouraging those counties, making it easy for them to band together, to work together and create the systems that need to be in place to get the necessary history. And I certainly think we need to encourage all investigations to be collaborative, and that means you need to develop relationships. In many jurisdictions those relationships are developing through child death review. I've been involved with meetings where literally I watch people who have never talked develop a relationship, and that happened recently where previously CPS never went out to scenes. But when law enforcement heard they were willing to come to scenes they exchanged phone numbers right in front of me and the next two cases CPS came to the scene. It was very helpful.

Those types of relationship-building activities, breaking down of the walls, are what is really going to move us forward in terms of investigation but also prevention of the next death.

Thank you.

Chairman Sanders: [00:57:30] Thank you. Lora Weingarden.

Lora Weingarden: [00:57:35] Good morning. My name is Lora Weingarden, I'm an Assistant Prosecutor in Wayne County. Wayne County is the biggest county in Michigan; it has the highest population. It covers 30 cities, including Detroit, and as you can imagine, we have a very high crime rate.

I head up the Child Abuse Unit. Nobody has ever asked me for statistics on how many child deaths we prosecute per year. I informally keep track, but my numbers are not accurate because they are based only on cases where the police have investigated, they believe a crime was committed, they believe they've determined who the perpetrator is, and they have gotten us a warrant package asking that someone be prosecuted. That leaves out a whole lot of prosecutions, and that is why my numbers are not accurate. The things that we prosecute are child abuse and neglect deaths at the hands of a parent, guardian, or caretaker. So that doesn't include things like drive-by shootings and gang-related murders of children or arson deaths of children.

We have many cases that we never see. Some of those include cases where there is more than one potential perpetrator in a home where a child was abused or neglected and the police can't determine who did it. Those are very, very frustrating. We have cases where we never see when the medical examiner determines that it's an accident, or the police consider it to be accident.

I attend the child death review team meetings, and I hear about these cases, and I seek out warrants because maybe it's not a homicide but it might be some lesser degree, like manslaughter, it might be a child abuse count, so that those cases don't fall through the cracks. And those sorts of cases that I'm talking about Dr. Mohr and Dr. Hunter already referred to: pool drownings, bathtub drownings, car accidents where maybe the child wasn't in a seatbelt or in an appropriate child safety seat, fire deaths, unsafe sleep deaths, and accidental ingestion of drugs and poisons. So while some people may consider them accidents, I seek out warrants so that we can review whether there was neglect, whether someone should be held accountable.

We're doing a lot of good in Wayne County. As you've heard, our child death review team is very, very strong. We meet monthly; we review a lot of deaths. I learn about some of the deaths that I have not yet heard of from the police, and I also am put on notice that maybe I should be expecting a warrant down the road, and if I don't get one I'm able to know who to call and how to get that so that we don't miss that death.

We have great communication between the Attorney General's office and the prosecutor's office. In our county, the Attorney General handles abuse and neglect cases in juvenile court. The Wayne County prosecutor handles the criminal cases. So often we have parallel cases but different prosecutors handling it. But we communicate well with each other; we provide each other with information so that both of us can be successful.

But there are many things that are not going so well in Wayne County. We have several cold cases out of Detroit where they were not investigated, and I'm talking about from about 2000 to 2010. We're doing a lot better now with more recent homicides or child deaths, but I wish we had the resources for them to go back and look at some of those unsolved child homicides so that maybe we can prosecute them.

We also have cases that were previously referred to our office that we denied, and I wish we had the resources to have the police departments go back and re-interview witnesses and reopen the investigation because I think now, with time passed, there may be witnesses willing to talk and tell the truth whereas they might not have been years ago.

Our own office, we're severely underfunded, we have a bunch of car accident cases where children were hurt or killed that we have not been able to review because we don't have the resources. I don't know if you've read this but we've lost 90 lawyers in the last year and a half, and we're not able to replace them. So we could do a lot better if we had funding.

Another major problem that I see in the state as well as the county is that there is no statewide or countywide database of children who have died. And I was thinking about what kind of analogy I could make to this. We have a sex offender registry in Michigan,

as there is in many, many states. We should have a child death registry in Michigan and it should be managed by the state police, like the sex offender registry is. Different people, like the medical examiner's office, the prosecutor's office, and protective services should be mandated by law to report these deaths to the statewide database and to the state police, and that way we won't miss any and we will have better, accurate counting.

In addition to the counting, I think it should be part of this database that the people who were in care or custody of the child when the child died should be listed on this registry. And I want to give you one great example of why that is so important. Several years ago, someone at the Michigan Public Health Institute recognized that one man's name appeared in the paperwork of two different child deaths. He was involved in two different child deaths. Once we determined that, we were able to compare the two cases, we were able to prosecute him on the second one using evidence from the first one. But had we not had some astute worker at the Michigan Public Health Institute find the name we wouldn't have known about that and he would be out on the streets today probably reoffending. So a database, I think, would be very important. The database should also have an area where it is recognized that "Yes, there was abuse or neglect" or "No, there wasn't," and then maybe an area for "It's arguable," because we don't all have the same definition of what is abuse and what is neglect. So I think those would help us count the deaths better.

I have one additional comment to make that really has nothing to do with counting deaths but I want to put this out there. We need public service announcements to the public urging them to report suspected abuse and neglect to CPS. You know, in many cultures it's not cool to rat out people, but we need to make it the right thing, the popular thing to do, and we need to change the culture in that respect. And the public service announcements with a 24-hour number would go a long way to doing that.

Thank you.

Chairman Sanders: [01:04:22] Thank you very much. Sergeant?

Sgt. Elizabeth Reust: [01:04:27] Hello, my name is Elizabeth Reust, and I'm the Chief Investigator for the medical examiner's offices in 12 counties in Michigan. Prior to working for the medical examiner, I was a detective with the Lansing Police Department, where I did child abuse and neglect investigations for 15 years of my career.

At the risk of being redundant, I am sort of going to skip around here. First of all, law enforcement does a terrible job of keeping track of child abuse deaths. The record management system that we used at Lansing Police Department didn't even have child abuse as an option, you entered it as an assault and then you would only know that it was child abuse based on the age of the victim, but it made it very difficult to pull numbers and to actually look at how many kids were being injured and that were dying

as a result of child abuse and neglect. I don't think that is unique to Lansing Police Department, I think that's probably true of most police departments in Michigan. The medical examiner's offices, on the other hand, is probably a great place to get numbers. It's relatively easy to count dead children in the medical examiner's office because all it is, is a function of age and the numbers there are much better.

The discussion that we previously had about the relationship between the medical examiner's office, Children's Protective Services, and law enforcement, I think, is the key to recognizing child abuse and neglect deaths and getting them investigated well. Toward that end, our office has developed a training program for the counties that we work in where the medical examiner's office, in conjunction with the prosecutor's office, puts on training for everyone who is going to touch one of these cases, beginning with the 911 operator who takes the call and including the emergency medical response people, the ambulance responders, the emergency room personnel, law enforcement, CPS, the medical examiner, investigators, and the victim advocates who ultimately deal with the families. And the idea here is that if everybody in a community knows what is expected when a child dies, it is much more likely to happen. They understand not only their role but the role of all the other agencies in the process.

What we found when we started this in Ingham County, and we've since expanded it and we're in the process of training six other counties, is that the quality of our death investigations has gone way up because the cooperation between law enforcement and CPS in particular and the medical examiner's office has gone way up. One of the problems that we had in Ingham County was this Central Intake. How do we get the message that we have a child death to the CPS workers? Central Intake takes a long time. We would call Grand Rapids and then wait an hour before the local office knew about the death. So we work around that, and what we do in Ingham County is that when we have a death, we still report to Central Intake but we also call the on-duty supervisor at CPS and let them know, "Hey, we've got a problem," and they can get somebody rolling before Central Intake gets the information to them. By doing that, CPS isn't left out at the beginning stages of the investigation, and that is so critical.

But if communities don't come together and have those phone lists and have those relationships, then the investigations are never going to work that well. I think that the medical examiner's offices are one of the keys to making this work well. They're the least offensive agency when you show up to investigate an infant death. People think the police are there because they want to take someone to jail; CPS is there because they want to take their kids, but the medical examiner is really a more neutral party in the eyes of the families. But the problem is that most medical examiner investigators aren't well enough trained to do these investigations. So that is one of the areas where I think we could focus our attention throughout the state and improve the quality of the investigations and thereby improve the quality of the number counting.

Thank you.

Chairman Sanders: [01:08:24] Thank you, really informative. Let's open up for questions from Commissioners. Commissioner Dreyfus?

Dreyfus: [01:08:33] Okay, well I want you to write our report. Would you do that? That was fabulous. Thank you so much. I mean it was not only informative, but the richness of your observations that led to recommendations of what could be done. So thank you, it was just great.

So a few things I wanted to talk about. First of all, Director Yager, you mentioned several areas where you saw barriers. And again, congratulations on the work the state of Michigan is doing, it certainly is impressive for the rest of the country. But you did mention some barriers. And one of those was around information sharing and your efforts to try to get that information, one of the things we are hearing around the country that continues to be an issue. Can you share with us where there might be federal, things that could be done federally, that would help this state in terms of data sharing—the ability for the different entities to have the data they need, when they need it, in order to move this forward? That's Question 1.

Question 2 was you talked about SACWIS and more enhancements needed in SACWIS. Again, anything federally that you would say would help the state in addressing some of the barriers that you identified as the things that are holding back continuous improvement.

Yager: [01:09:57] Sure, thank you. In terms of data sharing, that is absolutely a critical barrier. Saw a couple of things happen in Michigan that present opportunities both for good practice and for growth. Each county is mandated in the Child Protection Law to establish a joint investigation team spearheaded by the local prosecutor, and that was referred to previously. But funding is an issue in terms of these teams being able to come to the table, to spend time, and to collaborate around cases. Some of the smaller jurisdictions up north, as Dr. Mohr mentioned, don't have the funding to support that strong collaboration. I mentioned in my presentation the need for funding to support collaboration. It takes resources for people to step away from their daily jobs to come together and spend real time collaborating around specific cases.

I think one of the most important activities that occurs in Michigan is our Citizen Review Panel on Child Fatalities. They are a group of individuals and a collected group from the courts, the medical examiner's office, the ombudsman, and they come together sometimes for days at a time and collectively review the complete case file and have meaningful and robust discussions around that information and talk about recommendations to the department and to the legislature. But again, those things take resources. So there are lots of opportunities to enhance data sharing. We need to support local teams, they need to be funded so that they can do that, and they need

to be trained annually, as was spoken about. Those teams need to have regular training. It's not a one-time deal. They need to come together so that all of the members in that community team, the sheriff's office, the Michigan State Police, and local jurisdictions, the medical community, the education community, and the department need to come together regularly to encourage each other and to be trained in investigative techniques and collaboration. So there is an opportunity for funding to support those activities. When those things occur, good investigations occur, the quality goes up, the quality of the data goes up, and then we have data essentially because it is generated locally.

I think in terms of the second question, SACWIS, the federal government has been very generous in helping to support the development of SACWIS systems across the country. In fact, they have been pivotal in helping to fund the development of our SACWIS system. That said, not all states have SACWIS-compliant systems. One of the benefits of having SACWIS systems that are federally compliant is that it drives consistency in the opportunity to produce data nationally. One of the things, I think, that could impact this issue is to require certain elements around death reporting in state-compliant SACWIS systems. I think that would drive a little bit better data.

Dreyfus: [01:12:42] Thank you very much, and just one last follow-up question. So there is a report that is done annually, which is looking at all the child deaths and were there themes, recurrent themes and recommendations that are made that I assume cut across multiple systems, not just child protection. What is the teeth of that report? What assures the public that the legislature, the governor, the other systems that are interfacing and that have recommendations being made about them, that there is any follow-up on what those recommendations say need to be done?

Yager: [01:13:00] Yeah, currently there is no mechanism that would provide any kind of assurance that individual agencies, Department of Education, our department, the Ombudsman's Office, or any of the agencies are actually taking action on those recommendations. In terms of our own department, we track the recommendations; we provide a written response to each of those, and then follow up to make sure that implementation occurs. But again, publicly, they wouldn't see a lot of that activity.

Dreyfus: [01:13:45] Thank you.

Chairman Sanders: [01:13:47] So actually I saw almost every one of the Commissioners has a question or comment, so I'm going to go in the order, but I'll make sure that everybody gets called on. Commissioner Ayoub.

Ayoub: [01:13:58] Thank you. I have one question for Director Yager and one for Dr. Hunter. On the sharing of information, more specifically, you mentioned that unmet health needs and lack of supervision are not shared with CPS. Is there something in the works trying to change that, and what would be your educated guess of how the fatality numbers would change if they were included?

Yager: [01:14:35] I'll start with that. As you saw in our graphs, about 1,220 children die per year, on average. That was in 2011-2012. I don't expect much difference in 2013, but a little over 300 are reported to CPS. So there is a big gap there. Not that all of them needed to be reported, but nevertheless there is a significant gap. So a couple of things need to happen. Almost every panelist has mentioned the fact that we believe there is underreporting. We need the community to be educated, the public service announcements, we need to have appropriate materials out, mandated reporting guides, and we need to be in schools. My wife is a school counselor, and yesterday they had a presentation from CPS for all the schoolteachers and materials were handed out to train them how to report child abuse and neglect. So these things need to be happening in a very robust way. The roll-out of our Centralized Intake was a great opportunity to get a lot of public announcements out about the new number, about how to report, and about reporting, and indeed we've seen an uptick in complaints filed to CPS and that uptick has been sustained. So we are receiving more reports since the roll-out of Centralized Intake.

But we need to educate the community, and that is an ongoing activity.

Ayoub: [01:15:35] Thank you. Dr. Hunter, thank you for giving some clear examples of conflicting definitions of neglect. Do you think that it is a viable goal for this Commission to think that we could have a standardized definition of that, and if we don't, are we ever going to have a true understanding of the numbers?

Dr. Hunter: [01:15:58] It would be a lofty goal. I don't know that it can be readily obtained by this Commission. I think the discussion needs to occur. I think it's an ongoing discussion and I think that type of consensus may never be totally achieved, but I think it has to be reflective of our collective morals. I mean I think we have to try and wrestle with these issues, and it's an ongoing process. I don't think you're going to come to a definition that everyone is comfortable with, stamp it, and move on. I think you need to recognize that consensus, or at least some more agreed-upon understanding, and definition is important, and the process of wrestling with it is going to move us forward, but I don't know that we will ever…I don't think your Commission can certainly come to that consensus by yourselves, but I think initiating discussion and highlighting it as a problem gets the ball rolling in the right direction, because until then I think you're always going to be stuck with really underreporting. And as you continue to wrestle with it, continue to have the dialogue, and you document the dialogue, now you're going to start to understand the numbers better as they evolve.

Ayoub: [01:17:12] Thank you.

Chairman Sanders: [01:17:14] Commissioner Bevan.

Bevan: [01:17:18] Thank you. I have several questions for this panel. I have been very much looking forward to coming to Michigan because of the child death review teams, and being headquartered here, and I want to know a lot more about them.

One of my questions is that in Michigan law there are three different references to citizen review panels, child death review panels, and foster care review panels. And this is not unlike many places we've been to where these terms have been used indistinguishably. And my question is, are there not distinctions in terms of function of these different teams? So that's one question, what's the distinction?

My second is a comment in terms of these distinctions, because I've read in the children's rights journals and again in other places they refer to review boards as auditors, as providing oversight, and as determining effectiveness. And I don't see that consistently in reference to these three entities. My concern is that in the CAPTA legislation the reference is to citizen review panels and then the reference says that, "Fatality review and foster care review can substitute for citizen review panels." So in the citizen review panel there were questions about using a volunteer. And I think it was a different conception than what I'm saying in child death review. So I want to know what the distinction is, if you think we should be changing the CAPTA language and putting more requirements into fatality review, because I don't see where there are any federal requirements for child death. There are a few teams I see funding but I don't see any federal requirement.

Dr. Hunter: [01:19:22] Thank you for your question. So in Michigan we do have three panels and there are some similarities, but there are some very distinct functions within each of the groups. The local child death review teams come together and discuss a case collectively, and they fill out CDC forms, and they submit that to the state team. The state team then takes a state look at aggregate data and identifies trends and themes, and from that the state team makes very specific recommendations to multiple jurisdictions in the form of an annual report, and that goes to the legislature and to the department.

And then the Citizens' Fatality Review Panel has a very different function. That panel actually looks at case record material. So they're not looking at standardized forms that are filled out locally, they're looking at the case file. So a CPS worker would be reading law enforcement reports, medical examiner reports, the law enforcement officer.

Bevan:[01:20:22] Can you also identify the composition of these three? What's the difference in terms of composition?

Dr. Hunter: Yes. Sure. The local teams are the involved investigator, law enforcement officers, CPS investigator, typically a prosecutor, maybe school personnel, and CMH personnel. So those are local teams, and they meet on a local death when it might occur. The state team meets regularly, and when they meet they look at the

submission of information from the local teams, and the state team is comprised also of a very eclectic group, including the medical examiner, community mental health, the medical community, the ombudsman's office, and foster care review board. A number of individuals come together at that state team to look at the entire state's aggregate data and make decisions about that. The Citizens' Fatality Review Panel is a much smaller group, but it is also eclectic. We have the courts at the table, the medical examiner, law enforcement, protective services, the Office of Children's Ombudsman, and I'm sure I'm missing a few others. Those folks come together and that's where that specific actual case file review occurs, where they talk about a specific child, not state aggregate data but a specific child death, and they review multiple cases at each meeting, and at the end of the year they look back at their findings from individual cases and develop specific recommendations to the legislature and to the department in the form of an annual report.

Bevan: [01:21:47] Do any of them act as an oversight?

Chairman Sanders: [01:21:49] Dr. Bevan? I just want to mention that our next panel is focused specifically on the fatality review and, I think, we can give an overview, but we'll also have at least an hour of that too for the next one.

Bevan: [01:22:00] Okay, all right. So then can I ask one other question?

Chairman Sanders: [01:22:02] Sure.

Bevan: [01:22:03] Michigan has rejected the differential response alternative in terms of working with child abuse and neglect identified families. Can you tell me why? Can you tell me some of the reasons why?

Dr. Hunter: **[01:22:20]** Sure. We conducted research, my staff in particular, on the actual outcomes from differential response states and what we saw, really, across the country is that the outcomes really do not support any difference from our approach, quite frankly. We have a five-category system, which there is some similarities to differential response, but there are also some differences. Instead of diverting cases up front, we do require a full CPS investigation. The similarity is in our disposition. We have a middle ground called Category Three. We have a five category system, and in that middle ground we do not put the person on the central registry, even though abuse or neglect did occur, and we really focus on engaging that family around services to meliorate risks that were identified during the investigation. So it's less adversarial in that they are not being placed on the registry and they know we are there to support and help those Category Three cases. About 26 percent of our dispositions fall into that Category Three situation.

Bevan: [01:23:27] Okay, Thank you.

Chairman Sanders: [01:23:31] Commissioner Covington?

Covington: [01:23:35] Thank you very much for sort of illuminating the importance of a couple things, and I think one of them is the multidisciplinary investigation approach and how absolutely important that is, and I had a couple of questions, Steve, around that with you. You talked about how Michigan requires coordinated investigations, but how do you do that, how do you institutionalize that and how do you make sure it happens? And the follow up to that is, how do you think you could expand that into some kind of a national perspective around coordinated investigations?

Dr. Hunter: **[01:24:04]** I think one of the most beneficial aspects was having it codified in law. It's one thing to talk about best practices, but when you embed it in statute it requires the department and it requires prosecutors to develop local, meaning each county, to develop a joined investigation protocol to identify team members, to train them to work as a team so that they have specialized training in these egregious kinds of cases and sexual abuse cases. So I think that's pivotal; requiring local teams to do this. The second thing is to require annual training. I think that's a very important piece. If training is not required those teams will grow stale fairly quickly, or at least there's opportunity for them to grow stale very quickly. And Commissioner Covington, as you know, you need to spend a lot of time supporting these teams, and MPHI in Michigan, through a contract with the department, supports these teams rigorously. And so if the teams want to do well, and want to work well together, and have the opportunity to do that, MPHI is right there with them facilitating and strengthening their performance. I think that is also critical. You can't develop a team and just turn it loose. So those are some important factors along with funding. I mentioned that funding would also help any opportunity where teams come together and where they have to collect data, process data, and move it forward. It takes someone's time and energy, and funding is important.

Covington: [01:25:29] Another question is when I looked at the data sheet you put up, I think it was your very last slide, why is there a difference between the substantiated CPS fatalities of neglect? For example, in 2013 there were 89 but only 59 were reported to NCANDS. What's the difference there? We've been doing a lot of talking about NCANDS in all of our hearings; I'm trying to get a handle on it.

Dr. Hunter: **[01:25:53]** Sure. When we go out and investigate a child death, we don't look just at the child death; we look at the entire family. So we may go out on, say, a sleep death, and we may determine that there was no abuse or neglect in the death itself, but when we're there we may find a dirty house, or we may find another sibling with an abuse injury. So as a function of investigating that child death case, we substantiate abuse and neglect unrelated to the death but tied to the family. So the "59" is a subset of those where abuse and neglect is specifically tied to the victim child.

Covington: [01:26:26] Okay. I have a couple more.

You guys talked a lot about the issue of identifying neglect deaths. And so I get the sense of, "Where is the bar?" Dr. Hunter, you gave some really good examples about how you guys try to reach consensus, but the bar kind of shifts. I'm curious, and you represent a number of different jurisdictions within Michigan, and one of the things that we've struggled with a lot is where do community perspectives come into play? And in your feeling, do you think that race, income levels, and sort of the community standards have an impact on how neglect is identified across different communities in the state?

Dr. Hunter: **[01:27:09]** I'll field it first and then certainly anyone else can jump in, and this kind of comes from my work with the State Child Death Review Team. Those questions come up time and time again in cases where we think neglect may have played a role: poor supervision, or failure to protect. And what comes out is that they are very community-specific. What is okay in a rural community is not okay in an urban community. We, at the table, would share our backgrounds about where we came from, and what was okay in this situation wouldn't be okay over here. Anecdote: We remarried, and my children have step-siblings, and they would ride around on a golf cart. And I'll tell this story because now they are older and I can't get in trouble. But they would ride around on a golf cart, and the first time my children joined in on this activity with their step-siblings riding a golf cart, no one had helmets on, they were just zigzagging around, someone was standing on the back, and I almost had a stroke, I really did. I looked at my wife and said, "What is this?", and she said, "That's what they do. They ride on the golf cart and everyone has a good time." And I'm just seeing the head injuries, but in that community it was acceptable. So I think there is a real big cultural influence when it comes to talking about neglect; what is acceptable, what is adequate supervision, what is not adequate supervision? But I don't think that can stop us from talking about what a good minimum is, and even if it's acceptable in that community and it's tradition, it doesn't necessarily mean that it should still exist when it has definitely resulted in the death of a child. So I think there's always got to be cultural sensitivity. There are all sorts of practices in different communities that are acceptable, but again our priority is safety of children, so we need to have the discussion and start to look at maybe moving the bar closer to the standard. I don't think it will ever be totally standard, but moving it closer and saying, "Here are some bare minimums that have to be adhered to because the goal is prevention."

Dr. Mohr: [01:29:25] I completely agree with that, and one of the things, I feel that you were talking about public service announcements and things like that, is we obviously have to reach out to the lay public because there's going to be children, obviously, who are not brought in, especially if they are being neglected for routine medical care, maybe not even brought into the emergency department, but sort of redefining what neglect is for the general public. But again, I hit on this when I spoke before, but I feel it's tremendously important even among communities where there's this different definition, as Dr. Hunter said, the same thing for medical professionals. You could take 10 pediatric emergency physicians and have a different opinion about

what constitutes neglect. And I feel that we need to get rid of, and I've heard over and over and over again from physicians, "Well, it wasn't intentional." And we clearly know that there can be intentional neglect, but the majority of neglect is not necessarily intentional, so you have to look at the child. So I feel we have to do a lot of education and ensure that physicians know, and we go over this and over this again and again, that the threshold for filing a report with CPS doesn't involve any kind of preliminary investigation by the medical provider, whether that's EMS or an emergency physician. They have to know if there's even a hint of neglect they have to file the report.

Yager: [01:30:53] I would agree with both my colleagues that we definitely see variances in community standards, issues around day care, and availability for day care. You move into rural communities and you see 11- and 12-year-olds baling hay and driving tractors, and this is unthought-of in other circles. There are great variances across the state, and I agree we're never going to come down to such a specific and clear definition that there is no dispute, but I also think that, as Dr. Hunter suggested, we can close that gap, and we need to work very diligently to close that gap and do some good public education around those issues.

Chairman Sanders: [01:31:26] Commissioner Petit.

Petit: [01:31:27] Thank you, those are very illuminating presentations. Two questions and one observation. The observation is first, which speaks to the purpose of this Commission. The investigation that you all described, the multidisciplinary team investigation, is all postmortem. It is all after the fact that a child has died, and I would argue to all the Commission members, and all of us perhaps sense this but we need to reduce it to something specific, is that type of multidisciplinary approach needs to take place before the child is killed. And I don't know, David, whether it is going to be discussed on today's panel or future panels, but this business of all of these different disciplines, like the three blind men looking at the elephant in terms of what they're actually seeing, is a critical piece once we identify a child is at risk. So at some point, and if this is something you guys are already doing I'd like to hear it, but I have two specific questions.

One is if an open child protective case requires that in order for the child to stay at home the mother needs to stop drinking or be in active treatment and that somebody comes in for an hour every day and kind of oversees what is going on. And if, after leaving the household, the mother begins drinking and passes out, and a two- or three-year-old child who is at home goes onto the street and is run over by a car, is that treated as a pedestrian accident in this state? Is it treated as a neglect case? And do we know, and I would ask this, David, indirectly, not for answering now but in the future by the staff, in how many states would that be classified as a pedestrian death versus neglect death, or is it both? So that's one question.

Dr. Hunter: [01:33:21] I will speak for the department. In terms of Children's Protective Services, we would absolutely classify that as a neglect death due to lack of supervision related to the substance abuse. And related to your first question regarding the information, the importance around robust collection of child death information is so critical because we can take that information then and use it to develop predictive analytics, and we are learning from Hillsboro County, Florida about their use of predictive analytics, and we are now piloting it in one of our urban counties, Ingham County. So it is taking information about specific risk factors, screening families through those risk factors, identifying them, and then getting involved in engaging them before death occurs to meliorate risk and render that child safe. So I completely agree with where you are going, and we need to do a lot more of that; we are headed that direction in Michigan.

Petit: [0:34:17] Okay, so the second question related to that: In your chart on the Summary of Michigan Child Deaths, you expressed concern that there is a gap between the 1,234 overall child deaths and the 337 complaints made to CPS, but there is 900 there. I would maybe posit the fact that there is at least an equal concern about the gap between 337 total complaints made to CPS and only 73 total substantiated. It is my experience that while not everything rises to the level of satisfying the law in terms of abuse and neglect, there is frequently, subsequently, something that is going on and that in very few of these cases would it not be true that where there is smoke there is fire, and that there is something that is going on. So I'm concerned about this postmortem review, the 337, which is a substantial number, all the way down to 73, which is a small number. In other words, there is only 20 percent of those that are being substantiated as abuse or neglect, is that right?

Dr. Hunter: [01:35:19] Yes, I think that is correct. I think one of the big differences that we need to keep in mind here is in Michigan we have a very aggressive approach at the front end. And what I mean by that is we assign all sudden, unexplained infant deaths. Not many states do that in our understanding. So all of those deaths come in and when you do that, when you take that aggressive approach, you're going to then see a smaller number that are substantiated relative to the number that is assigned. So that explains some of that gap.

Petit: [01:35:46] If it was a comprehensive review from the beginning, wouldn't it tend to bring more cases into classification substantiation?

Dr. Brian Hunter: [01:35:55] Not necessarily. When you go out and do an investigation on a sudden, unexplained death, there is not a presumption that there was any foul play in that death. So indeed in many of those deaths, there is an explanation that is reasonable and appropriate, and some of those deaths there is none; a roll-over due to drug use by the parent, they are intoxicated and they overlay their child. So the idea is that we're aggressive in the front end in opening the net and investigating a lot of these cases.

Petit: [01:36:28] Yeah, I would say I don't necessarily associate all these cases as having foul play, even when there is abuse and neglect, for some of the very reasons that Dr. Mohr was talking about with these children being in a neglectful situation and what constitutes neglect. And the case that I gave, which I think is a pretty dramatic one in terms of an open CPS case and a child killed on the street. My experience has been most states would not classify that as a child abuse and neglect-related death; it would be classified as a pedestrian death. And I'd like to actually survey the states at some point and find out how they would indeed classify that death. How would the medical examiner classify that death?

Yager: [01:36:50] It would be considered a pedestrian motor vehicle accident, or pedestrian motor vehicle collision, and manner of death would be accident. It wouldn't meet our criteria to call it a homicide, but it highlights what I was talking about earlier. If that same mom deprived her child of food and slowly watched the child die, we would call it homicide. So there is, again, I want to highlight there isn't consensus on one form of neglect would fall under homicide, the other form of neglect cause is accident, and I think that is the type of thing that my organization needs to struggle with at the national level, but I think everyone needs to struggle with it and say: "How are we collectively going to handle these issues?"

Petit: [01:37:42] Yeah, because if it happened again two or three years later in a different situation, would it still be classified as an accident at that point? And that is the kind of recurrent behavior that you talked about seeing was the dual status, the gentleman that was cited twice in the article. One time, maybe it's not. After a second or third time you have to be very suspicious.

Weingarden: [01:38:02] From the prosecutor's office perspective, the first time in the situation you posed we would charge that mother with probably involuntary manslaughter and child abuse.

Petit: [01:38:12] Is it your experience that would usually result in a conviction?

Weingarden: [01:38:16] Usually they plead, so a conviction, yes, but it doesn't necessarily go to trial.

Sgt. Reust: [1:38:20] And her ability to charge it, though, would depend on the fact that law enforcement recognized it as something other than a motor vehicle accident. So it goes back to the training of law enforcement officers, which Steve mentioned has to be ongoing, and I can't stress that "ongoing" piece enough. The majority of officers who do child abuse investigations are not specialists in child abuse, and even in those agencies that are large enough to have a specialist unit, most of them only allow the detectives to stay in the unit three years because it's such stressful work. There is sort of this idea that we should rotate people in and out. Well frankly, it takes three years to get good at doing this kind of work. So the ongoing need for training can't be underestimated.

Petit: [01:39:05] So last question, is there a memorandum of understanding that links all of you together in this work that you're doing, or is it strictly on an informal, less-than-formal basis?

Weingarden: [01:39:16] The protocols that are set up for joint investigations that every county is mandated to have is the formal mechanism by which these investigations need to be done and how those agencies are linked.

Dr. Hunter: [01:39:29] But I think in the majority of communities there isn't that memorandum of understanding. In some communities, it still occurs because there has been more of an informal relationship building that has gone on, so it's functioning that way without a memorandum of understanding. But I would say, unfortunately, in a lot of counties that is not the case, and so codifying in the law should help, and continuing to reinforce with those communities that you need to comply. There is another educational piece that is important also, and Wayne County is blessed to have that relationship where prosecutors understand that if I call it an accident that doesn't mean they cannot prosecute. There are a number of smaller communities where if the medical examiner calls it an accident they would miss an opportunity to get CPS involved and miss an opportunity to prosecute because they feel that, "Well, the doctor called it an accident, therefore there is nothing we can do." And what I stress is that even if I, as the medical examiner in that situation, call that an accident in the manner of death, that doesn't have any relationship to what the prosecutor charges. So they can charge Murder 1, they can charge Manslaughter. They are not inhibited in any way, shape or form, and by having a dialogue between the medical examiner's office and the prosecutor, that understanding develops so they don't feel hindered, and that is part of that ongoing education.

Chairman Sanders: [01:40:57] Let me go to Commissioner Cramer for one last question.

Cramer: [01:40:58] Thank you, and I really appreciate all of your points of view. I want to zero in. It is a fact that we're still talking about some and many of the same issues we were talking about 20 years ago, that we can mandate by state law, by federal law as well. We've still got gaps, we've still got kids that are being killed, and we've still got investigations that prosecutors don't have details about. CPS is siloed, as you say, in its own world. Can you offer me an opinion of why today you think we are so siloed? My pride and joy was my Children's Advocacy Center programs, where the working teams came together and that law enforcement officer was willing to work side-by-side with the CPS worker, and the CPS worker was willing to kind of say, "Okay, I know I'm not supposed to be an investigator and a participant in this because my state agency is not so enthusiastic about this," but they did it. And they were check-and-balancing one another and sort of got in each other's face. We had a gap with medical exams that weren't being very completely done and evidence that wasn't being preserved so that when, as a prosecutor, I got a case it was too often

dependent on … and I'm talking about before death … a case that I got was too often dependent upon the testimony of a child. We were motivated by a child death in our community. An outrageous case, where two parents were accused of murdering their own kid, and there had been plenty of complaints in the system, the system had a chance to be involved with that family. There was a history of complaints that were years long. I sat there and listened to this case. I was a real rookie prosecutor thinking, "Why didn't we review together? Why didn't we know more as a team then we knew?"

Why do you think, and I'm robbing you of your time by continuing to talk on, in this day and time we are so siloed?

Dr. Mohr [01:43:16] Can I just add my own personal experience? I work very closely, we cover 21 counties in Michigan, we have a contract with the State of Michigan to provide second opinions regarding suspected abuse and neglect. We work with Jackson County, which I often describe as sort of a mini-Wayne County. But essentially, tremendous issues with child abuse and neglect as well as fatalities. There are two amazing, amazing detectives in one of the investigating bodies' jurisdictions in that area who are phenomenal. Because of budget cuts, there is now one person. They used to go out on joint investigations with the CPS supervisors, and had an amazing relationship. Now that there is one person he just does not have the time to go out with CPS, so we always talk about time and money but essentially, in my personal experience, it's time and money with regard to the situation.

Yager: [01:44:11] Two things came to mind in response to your question. Fear of turf infringement and a lack of common training. I think obviously budgets are tight, and when you start to talk about collaboration and multiple people, cross-training, people start to worry if their positions are going to be cut because of redundancy. I think fear of turf infringement is very real, and until we stress that more funding is going to be added to allow these types of activities to go on, you're going to maintain that. Fear of turf infringement is really big, in my opinion.

The second thing is lack of common training. You have people who feel that they are well-trained in something, and they are questioning whether these other organizations are well-trained. It took a while for me to convince law enforcement that my medical examiner investigators are a resource and they know what they're doing, and they are not going to come in and ruin your scene. And there is a real fear that they were inappropriately trained, inadequately trained, and so they wouldn't let them on the scene because they don't have common training where they all sat and trained together. That's where you get that silo approach. Those are the two things that came to mind for me.

Dr. Hunter: [01:45:25] Sure, and I would just clarify that I think in Michigan we do a pretty good job of breaking down the silos. In fact, nearly all of our counties have a

written joint investigator protocol document established by those local teams. Now the issues happen when those teams let that document become rusty and they don't provide annual training and keep it alive and active year-to-year. But by and large our teams are very strong and they work very well together, and that affords us the opportunity to have the quality data that we have today. That said, training is critical. And we can provide training but local jurisdictions have to have the funding to allow officers, medical people, and CPS staff to go to those trainings, to fund the travel, overnight stays, and those kinds of things, and we find that a lot of budgets are restricted and they don't have funding to send people, even when it is offered. So that drives us to create more creative trainings, web-based trainings, computer-based trainings, and those kinds of things. That's an area we're venturing into, but training is a critical piece. So while we do work very well in Michigan with over 20 advocacy centers, I don't know the current number today, very involved in these investigations and with very good collaboration, where it doesn't work is where those gaps still exist, where those jurisdictions don't get on board with us. That is where those gaps exist.

Sgt. Reust: [01:46:43] In my experience, one of the big problems with team collaboration is turnover on both the law enforcement and CPS side, and in particularly in Ingham County where I worked. The average age of the CPS worker, in terms of number of months that they have served, was months.

Cramer: [01:46:57] Is that a burnout issue as well, the turnover?

Sgt. Reust: [01:47:03] I don't think so. I think in this particular case it is they hire very young, inexperienced investigators, they come to Ingham County, they get their teeth wet, and they go to an easier county to work in. I think that's what we see in our county. And the other thing is that there is lots of training out there. There is lots of training available. Not very much of it is very good. We need expert training and we need advanced training, because once you've done the basic training you can't stand to do it over and over again.

Weingarden: [01:47:03] I'd like to comment on the burnout issue. I'm happy to say in Wayne County we have, for years and years now, the same people on the Child Death Review team, the same people involved in every aspect of child death investigation. Now eventually all of us old people are going to retire and we're going to need a new crop, but I think people who are as invested as all of us are, we're not burned out, and I'm happy to say that. We feel, and I think I can speak for all us, like we're doing very good, positive work and it energizes us, and I haven't heard anyone talk about burnout.

Dr. Hunter: [01:48:11] I'm a big believer in specialization and in training, and that on the front line that sort of prevents some burnout when the professions can support each other, work together, see the effectiveness of that, then you do have that longevity that you need.

Thank you.

Chairman Sanders: [01:48:32] Thank you very much. That really was an outstanding presentation and very informative, and we appreciate you taking the time and all of the preparation that it took to present to us. Thank you. We are going to take a break for ten minutes and then we'll reconvene with the Commission on the presentation on fatality reviews.

Morning Break: [01:48:50]

Chairman Sanders: [02:05:11] Welcome back, everybody. We're going to move into our next panel which, as I had mentioned earlier, is on the fatality reviews in Michigan and the implementation, recommendations, and outcomes, which is an important component of the work, that we are interested in hearing about how the information from the fatality reviews is actually translated into changes, practice and policy, and what the outcomes of those changes are. We are going to hear from Heidi Hilliard, who is the Senior Project Coordinator with the Michigan Child Death Review Program; Colin Parks, the Manager of the Office of Child Welfare Program and Policy; Paulette Dunbar, Manager of the Women, Infant and Family Health Section of the Family and Community Health Division at the Michigan Department of Community Health; Debi Cain, Executive Director of Michigan Domestic and Sexual Violence Prevention and Treatment; Tobin Miller, State Ombudsman Person; and Seth Persky, Office of the Family Advocate.

And we will keep this moving along, so all of you have relatively short timelines so that we have plenty of time to have questions from Commissioners. And we'll start with Heidi Hilliard.

Heidi Hilliard: [02:06:30] Thank you. I just wanted to start out my comments by noting that I am fighting a summer cold, so if I cough or break up I'm sorry, my voice is not what it normally is. I don't normally sound like Marlena Dietrich.

Just for clarification, I know there was a question earlier from one of the Commissioners regarding the differences, and I know it can be very confusing, between a Child Death Review Panel and Citizen Review Panels. Here in Michigan, we have local-level, county-level review teams. They are the ones that actually conduct the child death review at the local level. It is a voluntary process, it is not mandated here in Michigan. Despite that fact, we do have over 1,400 professionals at the local level that volunteer their time to serve on these multidisciplinary teams to review the circumstances of the deaths of the children in their community for the purposes of making those communities safer and healthier places for children. That is kind of a remarkable feat, having all 83 counties have review teams like that, when they are not mandated, when it is above and beyond what their normal job duties are. And I think that speaks to the great emphasis that the state of Michigan has put on this process over the years and the great folks that we have at the local level who are

doing this, not because they have to, but because they really feel that it is necessary. I mean children dying is obviously the worst thing that anyone can think of, and so to put their time and efforts toward that, I think, is very commendable and wise. We've been successful at multidisciplinary work here in Michigan.

Okay, so the local teams are not mandated. The State Advisory Team is. The state-level advisory team is mandated in law. It is made up of many of the same jurisdiction agency types that are at the local level, but they don't do case reviews. They look at the findings of the locals, they look at what our staff tells them that we are seeing around the state as far as trends, or things that are emerging or troubling, or issues that seem to come up again and again with our counties that we believe need to be addressed, and they review those quarterly and look at those trends and try to make recommendations yearly in an annual report to policymakers on how to keep children from dying in the future.

Now a subset of that State Advisory Team functions as our state's CAPTA Citizen Review Panel on Child Fatalities, so some of the members of the State Advisory Team also sit on our Citizen Review Panel. We do try to represent all of the disciplines at those Citizen Review Panels so that we may plug in others here and there where we need a different discipline if we don't have someone that's going to be sitting in from that discipline.

So it is an in-depth case review. What we do is we receive from the Citizen Review Panel on Child Fatalities, we receive the cases from DHS on children who have died that had CPS history. Our office then goes through that pretty lengthy list of children and determines, based on if it was a lengthy CPS history, if there was an open case at the time of death, or if the nature of the CPS history is directly related to the manner in which the child died. Those cases then go on for full panel review. We collect the case files from DHS, we also collect prosecutorial files, law enforcement files, medical examiner autopsy reports and put it all together and do a case file. I do this because it used to be paper and, honestly, these case files are about that thick and double sided. So our volunteer state-level CRP panel members really do put in a lot of their time to go through those cases, and it is multiple cases per meeting. We now use an encrypted stick so we're saving trees, but it is a lot of time and a lot of those folks are sitting in this room right now who serve on that panel and really put in a lot of good work and are some really fantastic folks.

The findings and recommendations that come out of that panel are submitted to DHS. DHS then submits it to the National Citizen Review Panel and they also have to respond in writing. By law they have to respond to our findings and recommendations of the CRP. So hopefully that helps clarify some of the questions, and I know it is a little funny because it is some of the same people. I do want to note that at the local level there is a case report form that was developed by the National Center for the Review and Prevention of Child Deaths along with several states that participate in

CDR around the country. And for each case that gets reviewed this standardized form is filled out with many, many variables regarding the circumstances that surrounded the death, the history of the family, the response, the investigation, service delivery, and questions about preventability. And that really is a great tool because it makes sure that these teams are looking at these cases in a standardized way, not that every team is exactly the same, obviously. Wayne County and the way they function is going to be very different than the way a county up in the Upper Peninsula might conduct their business. But we do allow for some of that flexibility just because we know that there is no two counties that are exactly the same. But that tool is very important in putting that information in, cleaning and analyzing it, and then putting out that annual report is how we can identify whether what we are doing is the right direction or if we need to enhance our efforts. So that is a good tool that we have here.

As far as changes in policy, legislation, or practices that have occurred as a result of these processes, there is kind of two tiers. Because this is a local-level process here in Michigan, much of the changes that happen as far as policy and practice occur at the local level. Sometimes when I travel around and I present about what child death review is and what has come of it, I give this analogy like … Well, obviously we do want state-level change here too. I mean that is what the State Advisory Team is for and there have been a great number of state-level changes that have occurred as a result of that, and I believe Colin can address some of those, and I believe Stacie Bladen later this afternoon on one of our most innovative ones on the Birth Match System. But at the local level, change can happen quicker. And I always do the analogy of the state being like a cruise ship and it takes a while to turn the direction of that cruise ship in a different way, whereas locals are more like a motorboat and they can make that turn a little bit quicker; they can make those changes happen a little bit easier. And so I think both of those tiers are very important.

As far as what could help us to make those changes in the future, I truly believe that if we had some federal funding for child death review, and I know that sounds self-serving; however, it truly would be a lot easier for us. We rely on the funds from DHS. They have been wonderful to fund us for the last 15 years, unfortunately that funding level has been the same for 15 years, and as you know the costs of doing business has gone up quite a bit in that time and they just don't have it to give us more. We are looking at cutting staff now, which we never have had to before, and it would really make our life a lot easier if we knew that there was that federal funding that could come down and help the states as the localities do this process.

Chairman Sanders: [02:14:32] Thank you. Mr. Parks?

Colin Parks: [02:14:38] Thank you, and good morning. I appreciate the opportunity to speak in front of the Commission this morning and to tell you some of the amazing work that our state is doing specific to the fatality review process. There are a number of folks who are going to be speaking about some of those specific review teams

today, so what I would like to do is provide you with a broad overview and to talk to you in some detail about some of the policy and practice changes that have resulted and to talk briefly about some of the results in regards to fatalities here in Michigan, and then to go into a little bit of depth in regards to the process itself, prevention, and early intervention efforts that have been a direct result of some of the findings of those teams.

Here in Michigan, we are very fortunate in the fact that we have six fatality review teams. We have our local child death review, which we have talked about at some length. Those teams do take a look at both abuse and neglect deaths, but they also take a look at non-abuse and neglect deaths, as does the Child Death State Advisory, although the majority of both of those are linked back to child abuse and neglect fatalities.

And then of course we have the Citizen Review Panel on child deaths, the Office of the Children's Ombudsman, who is accountable to the governor's office, the Office of the Family Advocate, which is internal to DHS, and the State Court Administrative Office.

We talked earlier about silos, and one of the things I would like to point out in regards to these fatality teams is I don't think that is an issue with these teams. I think that they collaborate well and often, and as Heidi mentioned, many of those folks on those teams coordinate with other teams as well, so there is very good integration.

CPS policy and practice change. A number of recommendations come out annually from all of those teams. Many of them have resulted in very effective changes in terms of policy and practice for our department. Those include, but are not limited to, the death scene investigation checklist, required by law. Safe sleep policy and practice—Michigan has been very innovative in terms of how it addresses safe sleep deaths. We have incorporated both into policy and into law. Here in Michigan, in May of this year the governor signed the Safe Sleep Act requiring that all hospitals notify and educate parents about safe sleep and require that parents who are educated acknowledge that they will practice safe sleep.

Steve earlier talked about some of the mandated reporting and training work that we are doing here in Michigan. For many years we saw a decline in mandatory reporting. The last couple of years we've seen that start to tick upwards, and I think that is a direct result of some of the training that we're doing.

Again, there was mention earlier of the sudden, unexplained deaths. Michigan investigates all infant sudden unexplained deaths, and we are required to do a preliminary investigation on all sudden, unexplained deaths of all children. We also have the Birth Match System, which Stacie Bladen will be talking about a little bit later, and we also have safety and threatened harm training. Our department has

looked at providing enhanced safety assessment and safety planning training, and also threatened harm training, to all of our staff statewide.

These are, again, some of the same numbers, and in fact it is the same slide that was brought up earlier. I do want to indicate as Steve did, although there is a decline in those overall deaths over the past three years, there is really no ability to say this is a trend. However, I would like to say, based on all of the practices that have been institutionalized inside our state, there is a cultural shift, and there is a focus on safety, and there is a focus on trend.

Fatality reviews, again, really require that we take a look at abuse and neglect deaths primarily. Our office, CPS Program Office, is involved with all internal and external death review processes, and we are responsible for all departmental responses to the recommendations from those teams.

In terms of information that is utilized during the review process, I would like to emphasize it is more than just review of the case file, it includes mental health reports and assessments, it includes educational records, substance abuse treatment records, law enforcement reports, medical examiner reports, and I think most importantly it includes engagement with frontline staff, and talking with them to try to find more in-depth information about the case that can't be seen in that case file.

I'd like to talk briefly about the review of prevention efforts. Inside all of our fatality review systems we take a look at what services were those families provided prior to the death of their child, and where are there some gaps. One of the things that we have seen through many of those teams is that workers need to assess and plan for child safety better. And our department has really prioritized this as an issue of great importance. We have required a safety assessment and planning training for all of our child welfare staff throughout the state of Michigan, to do a very comprehensive assessment of child safety and to plan around it. Before you leave that home, what have you done to mitigate the risk that you've seen in that home?

Threatened harm requirements are also a huge issue for this department, and we have also started providing a training around threatened harm, to take a look at not only services provided but the evidence of benefit from those services. It's not enough to say that we provided a family with a service, but what was the gain, and how was the risk meliorated?

And finally, opportunities for early intervention; One of the running themes here so far this morning has been we need to get to these families prior to CPS involvement. How do we do that in Michigan? I spoke at the Safe Sleep Act, and we are very, very proud of the work that we've done in terms of safe sleep. Unfortunately, Michigan as many other states have not seen a substantial decline in these deaths, despite all this work. So we have put the Safe Sleep Act into effect. DHS helped to draft and find a sponsor for that bill. We are also taking a look at engagement with people even prior to any

type of CPS involvement, by having first responders go out and speak to families about safe sleep and to help identify safe sleep concerns. We've also done a very expensive media campaign here in Michigan, utilizing parents who have lost children as a result of unsafe sleep, and had them speak about their experiences as a way to really engage parents in a different way.

And so finally, services provided to families and subsequent benefit of those services is always part of the child death review process, but for us the focus is we need to get into those homes and help assess safety prior to CPS involvement.

Thank you.

Chairman Sanders: [02:22:34] Thank you. Ms. Dunbar?

Paulette Dunbar: [02:22:49] I have responsibility for the Fetal/Infant Mortality Review process in the state of Michigan. The entire division is responsible for helping to reduce infant mortality, but we take a public health perspective on the fetal and infant mortality reviews. In fact, we consider it a public health surveillance activity, and primarily it is like a child death review process to identify factors that contribute to fetal as well as infant deaths and their intent. These are all local processes, and their intent is to identify strengths and weaknesses in the community and what is needed, and process and evaluate each individual case.

The FIMR goal is to identify patterns, identify where they need to improve community resources for women, children, and families; improve perinatal care system services; and to find solutions to improve the outcomes for families.

FIMR objectives. They are looking at a host of contributing factors to death: health, social, cultural, economic, safety, and systems contributions as well. To design and implement a community-based action plan that will help them as a result of their particular reviews.

It is a two-step process. The Case Review Team, made up of again multidisciplinary folks in that community who review the identified cases. These are those cases that are sitting on the fence and they are looking at trends and identifying factors and findings. Step one also includes the development of the initial recommendations. These are initial recommendations. They send those recommendations on to the next group, which is called the Community Action Team. The Action Team is responsible for taking the recommendations and truly creating the way of identifying, "How can we take action here to solve this problem for our community?" So they will try to devise creative solutions to improve their services and improve access to resources and to prioritize and implement interventions.

The FIMR takes family violence and neglect into consideration. They look at history and current abuse for the moms of the children. We see a continuing connection there

if mom has had a history or is involved in an abusive relationship, and if this is a factor for her abuse or allowing abuse of her child. They also look at history in current abuse of a particular infant and the indicator that has died and any other children as well. So it is a more comprehensive family look.

Now as to the frequency of abuse, to give you a sense of what we're finding in these 16 or so communities that fortunately have the resources to conduct FIMR reviews. In 2011, of the 159 cases reviewed, 13 had an indication of child abuse or neglect. That is not to say it was the primary cause, but at least there were some conscious, contributing factors. That is 8.2 percent. In 2012, of 157 cases, there were 10 and that is 6.4 percent. When you look at the year of the view, which is a slightly different population group, you see that the percentages are still about the same, so we're not seeing a lot of change where abuse and neglect is a factor in about 6 percent to 8 percent of the FIMR cases, and these are infants.

Colin has talked about safe sleep, so I won't spend a lot of time on safe sleep, but just to reiterate the difference, public health takes a perspective of regarding safe sleep as a factor related to health, safety, and cultural practices, and not necessarily identifying it as neglect. We see it as a need to change cultural practice of child rearing practices.

We just wanted you to see the numbers of safe sleep. As Colin has already indicated, we have put a lot of work into trying to reduce the number, but as you can see, our dosage and our sufficiency and the needed combination of interventions still have not had much of an impact.

Colin also covered the fact that one of the statewide perspectives has been our Public Act 122, signed this year into law. FIMR uses the review authority of the Federal Privacy Laws and the Michigan Public Health Code to gain access to information, and they have a pretty good track record of being able to get what they need.

The important part for FIMR, while it is looking only at infants, that important part for us is that the counties that are able to put together the resources they need for conducting their FIMR serve about 65 percent of infant deaths in our state and 85 percent of the black infant deaths in our state. That is particularly significant, because Michigan has a significant black infant death disparity in our state, which we are working very hard to try and eliminate.

Chairman Sanders: [02:29:41] Thank you very much. Ms. Cain.

Debi Cain: [02:29:51] Chairman Sanders and Michigan members of the Commission, thank you for the invitation to be here today. I am Debi Cain, the Executive Director of the Michigan Domestic and Sexual Violence Prevention and Treatment Board, a seven-person governor-appointed board housed in the Michigan Department of Human Services.

As a member of Michigan's Child Death Review Team, I bring before you today a particular lens in the way that I look and review the child abuse and neglect fatalities, based on my background in domestic violence and sexual assault.

The intersection of child abuse and neglect to issues of domestic violence, mental health, and substance abuse is well established. In many cases, multiples of these three issues are present in cases, and they each significantly impact families, and yet there is frequently a disconnect in the understanding that the well-being of the child is powerfully affected by domestic violence.

In my 15 years as the executive director of the Oakland County domestic and sexual violence agency, Haven, I saw numerous cases of domestic violence that had the presence of child abuse and neglect. On a particular note, I would like to mention that for 15 years we tracked—as an agency that did a substantial amount of work in incest as well as domestic violence—we tracked that a third of those cases where we saw incest, domestic violence was also present. And it was my experience that the presence of domestic violence significantly changed the approach and the family dynamic when dealing with incest in the context of domestic violence as well.

As a member of the Michigan Child Death Review Team I have two primary observations that I would like to share with you, based on my domestic violence experience. As you heard Colin state, in the majority of child death review cases that we looked at, multiple systems have been involved, and domestic violence is generally missed or, even more accurately, ignored by the majority of those systems. While professionals may have received training on screening for domestic violence, there is definitely a need for training and guidance on how best to respond to the intersection of child abuse and neglect and domestic violence, and that is understandable because domestic violence is a very onerous issue to deal with on its own.

All systems, when responding, tend to focus on the adult victim of the domestic violence. For instance, case planning or action steps that are outlined tend to almost exclusively focus on the nonoffending parent and look at actions such as encouraging her to leave the home, kicking him out of the home, giving her some protection orders, insisting that there be no contact, that she go to parenting classes, that there be forced domestic violence counseling, etc. And while these are all well-intended approaches, the reality is that they are generally approaches that are not particularly effective. What we are learning now, though, is that there are effective approaches in dealing with domestic violence, particularly as it relates to child well-being. And I'm very proud and excited that here in Michigan, under the leadership of Director Corrigan and the wonderful staff that we get to work with on the Child Death Review Team, and with the leadership of those in the child welfare arena, we are looking at a very comprehensive approach that begins to put the focus more where it needs to be, and that is on the perpetrator of domestic violence, and we are trying to address that issue.

We're looking at comprehensive child welfare responses through policy, through approach, and through training to ensure that domestic violence is woven throughout the child welfare programming and services here in Michigan. One such initiative that I am particularly excited about is that of the Safe and Together training model, which is led by David Mandel, someone who is doing training across the country for child welfare agencies. David's training actually focuses very specifically on perpetrators of domestic violence, how to screen, how to focus on change, and engagement and accountability. We believe, in Michigan, that incorporating this training approach will be an important step to moving us forward as a state and better addressing domestic violence in the best interests and well-being of children.

The second observation I'd like to share with you relates to the need for better collaboration between systems and professionals as we work to ensure the well-being of children. For example, in domestic violence, to meaningfully address the presence of domestic violence, which often includes the involvement of the criminal justice system, since many aspects of domestic violence are indeed criminal behaviors. Michigan has excellent domestic violence laws, but the effectiveness of those laws and interventions are only as good as the community and system response around them. A wide collaboration of community response can reflect a greater safety net for both child and adult victims when domestic violence and child abuse and neglect coexist in the family. Such collaboration can better ensure cohesiveness in how the family and criminal courts respond to domestic violence. Community collaboration can ensure that domestic violence support and access to voluntary services are available for adult victims of domestic violence.

I particularly want to thank one of the earlier speakers today, Ms. Vivoda, for her generosity in sharing her personal experience with domestic violence and her astute observation that she desired support for the domestic violence that she was experiencing. Community collaboration offers the opportunity to also engage domestic violence perpetrators who are the cause of the domestic violence both by creating accountability for the violence but also offering opportunities for their choice to change through the use of valid intervention programs and responsible fatherhood programs.

In Michigan we, through the Violence Against Women Act, have for nearly 20 years now had programs in all 83 counties of Michigan working to ensure this collaboration. While we have largely focused on the criminal aspects, we are working much more closely with our board, with Director Corrigan, and our colleagues in the child welfare system to look at how we can better, especially through the implementation of Safe and Together training, ensure that there is a broad community collaboration that will include criminal and family courts, prosecutors, health and medical people, child advocacy centers, victim advocates, law enforcement, batterers' intervention, and fatherhood programs, among others.

I thank you for the opportunity to discuss the urgency of our need to effectively and safely address domestic violence in our quest to protect children in Michigan. Thank you.

Chairman Sanders: [02:36:54] Thank you. Mr. Miller?

Tobin Miller: [02:36:58] Good morning, my name is Tobin Miller. Thank you very much for the opportunity to appear before you this morning on behalf on the Michigan Children's Ombudsman, Arlene Hawks. The Office of Children's Ombudsman is an autonomous oversight agency, a complaint office for the Michigan child welfare system. We receive complaints and inquiries from the general public and attempt to educate the public about the system and make referrals to other entities that are appropriate to address with concerns; we conduct investigations of cases, advocate for children, and advocate for needed changes to law and policy.

In terms of our participation in the Death Review system in Michigan, it typically starts with a DHS child death alert, which comes in to our office via email. The slide here shows the cases that DHS is required to send to us, and this is in the statute. Note that these criteria are broader than the criteria we use to determine whether we will actually open an investigation. This allows the Ombudsman some discretion in opening a case that doesn't meet our more limited criteria. Those criteria are listed here. These were established internally, and they will be in the statute effective September 25, 2014, so in about a month. The amended statutory provision, of course, will require us to investigate complaints meeting these criteria. So we won't be screening any death alert that meets these criteria out. We will be looking at all of them. I would note too that, as a complaint office for the general public, that we may receive a complaint regarding a death from a member of the general public and the Ombudsman, of course, has the ability to open up an investigation based upon that complaint and has the ability to open an investigation of any case that comes to the Ombudsman's knowledge. Then at the bottom you can see just the numbers there for fiscal year 2013. We received 270 death alerts and we opened 77 child death review investigations.

In terms of our access to information, we are reviewing the record made by the agency, and we have the same access to information that the child welfare agencies do: medical, mental health, substance abuse records, and of course the case file record itself that is made by the agency. We also may update information through public sources. We do have subpoena power, and rarely do we need to use that but it is there as a tool.

In terms of the focus of our investigations I just note that these are broad, obviously broad areas of focus, but our main goal is to compel compliance with existing law and policy, and we rarely, but do occasionally, make recommendations regarding poor practice in a case. But our main goal is to compel the compliance, to identify

instances where the agency or agencies involved did not comply with their own policy and the law that applies to them and to identify those instances. I would just note too that based upon the facts of the case, of course, we can add specific concerns to what we're looking at.

These are the focus of investigations for foster care cases. We review, of course, both CPS cases where children were involved with child protective services and were in foster care.

The results of our investigations are, if we identify law or policy violations in any case, we will issue what is termed in the law "a report of findings and recommendations" formal report. And we issue what we call the "F&R" to the agency when the violations that we've identified affect the case outcome. So we do have mechanisms by which we can close out an investigation administratively if we determine that the violations that we have identified did not alter case outcomes at all.

Our recommendations are intended to improve agency practice, obviously, and those are issued to the agency. We also make recommendations for systemic improvements, and we give those to DHS or other identified agencies. Our annual report focuses on broader systemic improvements, and we submit that to the department, the governor, and the legislature.

Just in terms of changes, very quickly, as I mentioned before, our law is changing in late September, and we will be able to issue recommendations to legal and medical professionals involved in a case. Those recommendations are to be of a more systemic nature. And then you can see there some of the examples of DHS policy that resulted from our case reviews.

Thank you.

Chairman Sanders: [02:44:09] Thank you. Mr. Persky.

Seth Persky: [02:44:14] Good morning. Thank you for the opportunity to talk about the Office of the Family Advocate this morning. My name is Seth Persky and I am the Acting Director of the office.

Who are we? So the OFA is a small unit within the DHS Executive Office. We are internal to DHS, and DHS is our employer. I report directly to the DHS Executive Director. Our major duties around fatalities include doing the internal state-level CPS and foster care fatality reviews. The locals do their own, and we kind of do what I would consider the official DHS review. I serve on several of the state review teams that you've heard about, and our office is also the liaison office between DHS and the Office of Children's Ombudsman, so we are kind of the go-between between the local offices that have to respond to the OCO questions and reports, and we kind of fashion the DHS official response.

So where does it all start when completing a fatality review? Well, when someone calls our centralized intake or CPS Centralized Intake, a doctor, the foster care agency, whoever, that prompts a child death alert through MiSACWIS. It comes to folks at my department, we distribute that death alert, it goes to Tobin, it goes to Heidi, so that they are aware of the death and their processes can start, and that is where our process starts as well. When it comes to foster care reviews, we have six months to complete a foster care fatality review.

In 2014, this year, we started completing the CPS fatality review, so we'll talk a little bit about those. Those were done by another unit. There are a lot more of those that need to be done in the state, and the unit that was doing them was a lot bigger, and we got smaller, and we needed to find a new home in process, and in talking to folks in the field and in thinking about it, we already did the foster care ones, we work with the Ombudsman, and it seemed to make sense for it to kind of come back to the OFA. So we do all CPS foster care fatality reviews now.

So what makes us different? We're a dynamic little unit in DHS. We have immediate access because we are all DHS. We have immediate access to MiSACWIS, all the information on it in real time concerning the cases as they are unfolding involving a fatality. Our position allows us to coordinate and provide information between any DHS office from local, to Communication, our program office, and so we can really serve as that kind of lynchpin for a lot of it, especially in the high-profile cases we are getting right in there right away. One of our benefits is we are all child welfare experts. We have all been in the field and with foster care, both my staff and CPS, juvenile justice, and foster care. And through our other duties and through these duties, we interact with hundreds of staff all over the state continuously, so we know everybody. So when things like this happen in smaller counties, when they have a fatality and they're not used to working through the process, "What do we do?" and "There is a newspaper reporter, and how do we do that?" So they are free to call us and consult with us, and we are free to pass that on to any other unit that we think needs to be involved with the fatality. And sometimes it's just us backing off and just letting them do their good work in the county and then coming up afterwards with our review. So we know folks and we know how to respond to this.

Our office is often the first that is aware of trends and issues which impact services across the state. I will talk a little bit about that in a minute. We come in after the death, but from what we learn, we can sometimes very quickly affect policy and practice at DHS to prevent deaths from happening.

So a little bit about our numbers. For our foster care fatality review we did 16 reviews in 2013, 17 in 2012, and 16 in 2011—[*referring to slide*] a graphic from our annual report, and we post those, it's on our public site, that's the link to them. The numbers have been fairly consistent. I do have to say we did go for a period this year, four months, without a ward death. We get one or two ward deaths a month in Michigan.

We have 11,000 kids in care. You know, 16 deaths in medically fragile children, a whole host of reasons. So the numbers are small, thankfully, but we learn a lot from these cases. We did go four months without a ward death, which I have been in that unit for 5 years, and we just went another month as of yesterday without a ward death. So our numbers are low this year.

For CPS fatality reviews, a criteria for review is if there is anything open or active, if they have had three previous investigations, and if we've recently closed a case where we were working with the family and there was a death. Most of those deaths are unsafe sleep-related, those deaths. We review the case and we are anticipating 50 to 60 this year.

Kind of finishing up, we have really access to everything. We can look at the entire CPS foster care and foster home file, we can go to any kind of document from a local county; being an executive staff does have its privileges. If I'm going to call a county and I want to look at something, we can talk directly to workers and local staff and vice versa, and our findings are reviewed with the Executive Director, a Children's Rights plaintiff, and the Children's Services Administration Program Office. Our local offices, of course, get a copy and our State Court Administrative Office. And we now require, after review, that our staff go out and sit face-to-face in the county with the worker and with the administration there and talk about our findings. Even if it was an affirmation and things went well, we want to talk about those things. A case is a mix of good and bad things. I think sometimes we jump to the bad things, and we want to fix those. The good things don't take away from the bad things, but the bad things don't take away from the good things in cases. We really want to talk about those with our county folks; how can we make that work more statewide.

And lastly, from our reviews, from our office, things that we have been able to be involved in and help out with is starting a suicide prevention and depression management initiative. In cases where there is a death of an older child, we're looking at homicides and suicides, usually. There is a lot of attention, lately, to unsafe sleep and that is great. We want to kind of put some focus on our older children in care, and we're talking about suicide prevention and depression management. We have been able to kind of help start an initiative around that.

We do internal fatality webcasts or educational pieces. We are part of the safety assessment planning that Colin talked about, the new child welfare database that we administrate, and other folks have talked about. We're really focusing on the issue of secondary trauma of our workers. It is very difficult for our workers. A young person who does two or three of these, and looks at autopsy photos, and it is very challenging doing it, so we want to debrief with them.

Thank you.

Chairman Sanders: [02:52:04] Thank you very much for the presentation to the entire panel. We probably have time for four questions from the Commissioners. So Commissioner Petit?

Petit: [02:52:15] Thank you. This is really directed at Colin Parks. You said something about the actual numbers of fatalities not really declining very much but that there is a cultural change. And I looked online and saw that the numbers held steady for the last 7, 8, 9, 10 years. You come in with about the same number each time. And there is no question that listening to all of you and the panel previously reviewing all the materials, that Michigan is doing a tremendous amount of work in terms of addressing the issue.

On the other hand, I put this in the "pleased but not satisfied" kind of category because the numbers of deaths are not dropping. So what is it going to take for the deaths to actually start dropping? Is it bringing some of this to scale? Put aside for the moment the temptation to say, "Let's prevent everything, let's have every child wanted, every child loved, every family not living in poverty," put that aside for the moment. Just what will it take for those of you that are dealing with this on a day-to-day basis, what you think is it going to take to actually have the numbers drop? More than cultural change, in actual dropping numbers.

Parks: [02:53:23] I think for us what we have seen in terms of the most effective approach would be the most analytical of a scientific approach. Taking a look at what Hillsboro County has been able to do in terms of their reduction of child deaths, and utilization of predictive analytics. Steve mentioned earlier where we are developing and have developed a pilot in Ingham County. In that case, although we don't have the number of child deaths that Hillsboro County encountered, we do have a big issue with maltreatment rates. And the hope is that utilizing that same sort of predictive analytics model, we can approach those repeat maltreatment rates and perhaps apply them to child death cases as well. And I think for us, what we know is that there are predictive factors in these deaths. What we know is that there is an approach that we can use to affect those numbers. We haven't had the ability to utilize that statewide, and we haven't had the ability yet to use them on child deaths, but I think that's an approach that seems to be the most effective and fruitful that we have seen.

Petit: [02:54:35] You don't have the ability because of what? Why not?

Parks: [02:54:37] Well we have just begun to use it. We went down to Florida and met with DHS down in Florida and we met with the Eckerd folks a few months ago, and so we are beginning to develop it, but I think through the coming years we will continue to utilize that approach and I think that we'll have better outcomes.

Chairman Sanders: [02:52:02] Commissioner Bevan.

Bevan: [02:00:50] Hi, and thank you very much. I've been looking forward to this panel, as many of you know. Given the testimony I heard today, there is considerable overlap in the composition of the Citizen Review Panel, the Fatality Review Panel, and the Foster Care Review Panel. And all these teams seem to be composed of DHS members, Michigan Department of Community Health, the medical examiner, law enforcement, hospitals, educators, prosecutors, courts, child abuse physicians, EMS, ombudsmen, and other state entities. What assurance can you provide the Commission that these panels can fulfill the independence that is required under CAPTA? Under CAPTA, the panels are required to audit, to evaluate the effectiveness of departments that the members of these teams, in fact, represent. So I am concerned about the independence and the ability of the "who is going to watch the henhouse." Can you give me some idea, some assurance that there is some independence, or none, and who has oversight over these panels?

Cain: [02:56:36] Well, for the Citizen Review Panel on Child Fatalities, which is the in-depth case review of kids with significant CPS histories which occurs at state level, the chair has been, historically, someone not involved in the direct child protective system. We've had a law enforcement officer for many years who was the chair of that committee who has just stepped down, and we are replacing that person with another person who is not involved with DHS. I will say when we started this, because of concerns like what you've just brought up, DHS, when we would do these reviews, we tacked them on to the end of our State Advisory Team, since everybody was already in the room. DHS would get up and leave, and we would have the discussion without them because we thought that was "fox in the henhouse." However, it became very clear that was not the most effective because we were not aware of all the policies and practice implications, maybe things they had tried in the past that didn't work, and unintended consequences. We were making recommendations that weren't as effective as they could be. So then we did involve DHS at that point. And how do you ensure that? I'm not really sure what the answer to that is.

Luckily we have it, in those rooms you should hear the discussion. It is very frank; it is very open. These people have known each other for many years. They put their opinions out there, believe me, there is no holding them back. We happen to be lucky in that case. I don't know how you replicate that in other places, but there is no one that is holding back on saying something because of who is sitting in the room. We have very active discussions.

Parks: [02:58:23] I would add from a DHS perspective, although we are involved in those, if ever, in my opinion, it becomes an adversarial experience, there is ownership over mistakes that we, as a department, have made and improvements that we, as a department, need to make. And those come through on those annual recommendations, and as you've seen, often times it results in very good systemic changes to our practice. I think we do have an honest and frank discussion in those meetings, but I don't think it is ever encumbered by our role in the department.

Miller: [02:59:00] I would just add too that the ombudsman, in terms of our office, we are independent of DHS and any other state agency. We are structurally isolated from them and under statute, nobody has the ability to review our findings and recommendations before we issue them. So we are independent.

Persky: [02:59:29] If I could add, we are a closed group, too. So the same people over and over and over the years. You can't send a substitute; you can't send somebody else. It's not somebody new every time, it's the same people every time, and that makes a big difference.

Chairman Sanders: [02:59:42] Commissioner Dreyfus.

Dreyfus: [02:59:49] Thank you, I have a couple of questions. Mr. Parks, you were talking about, obviously, substantiated cases that have been the determination to screen them in. But I'm thinking about the screened-out cases and the ones that are not substantiated. And what do we learn there? I recently met with a child protective center in Wisconsin, and one of the things they were showing me was the data on all of the cases that are not substantiated, that supposedly there is a referral to services but no closing of the loop of whether or not those services actually happened and was there any change. So I appreciate it when you talked about that from a substantiation standpoint, but is there anything going on in those cases that are not substantiated, where there is a referral to services, but do we know if they got them, if it made any difference? That is question one.

Parks: [03:00:50] It can become a struggle taking a look at cases that we have opened or perhaps denied and we provided some sort of services. As Steve indicated, we've got a multitier disposition system, and with the exception of our Category 5 cases where we find absolutely no preponderance, even in the denied cases, our Category 4 cases, we require some sort of access to services and sort of provision to services. In those cases, because they are not denied, although services have been offered, we don't have any way to track as to whether or not those families completed services, until and unless those cases come back to us and we're able to monitor whether or not they have received those services and there was some sort of a benefit.

With our other category systems, with the 3, 2, and 1, those are all preponderance findings, and in most of those cases we do track those services by opening cases, services, provision, and ongoing CPS involvement. Now there are some of those Category 3 cases where we open services and we close them, but we do send a letter out to the service provider and ask that they provide us updates as to whether or not services have been accessed and whether or not there has been some success in those services.

I would suggest in all but the Category 4 cases, we do a pretty good job of monitoring services and making sure that folks benefit.

Dreyfus: [03:02:24] Okay, thank you. Ms. Dunbar, I want to ask you a question, if I could. First of all, what is the definition of "infant" that you are using? And is it consistent across the state? I've heard the term "infant" multiple times today, but what is the definition of "infant" in Michigan?

Dunbar: [03:02:38] A child up to the first birthday.

Dreyfus: [03:02:42] Up to the first birthday. So that is not up to age 2, it is up to the first birthday. Is that a consistent definition of all the times we've heard "infant" today, that it is up to age 1?

Parks [03:02:52] Yes.

Dreyfus: [03:02:53] Okay, next question. You mentioned eight factors. You mentioned safe sleeping as one of those eight factors in your reviews that you have found to be prevalent in child death. Not that I want you to go through the seven today, but could you share with the Commission and with our staff what those other factors are?

Dunbar: [03:03:15] Well, we look at educational factors, there is social and emotional factors, there are health factors.

Dreyfus: [03:03:24] I just meant more in terms of what your findings have been on more than safe sleeping, but what your findings have been and if there was more you could share with us.

Dunbar: [03:03:31] They are all local. I'm sorry, I didn't review them.

Dreyfus: [03:03:59] Thank you. One last follow-up, Mr. Miller and Mr. Persky. So I'm a former child welfare director, and I appreciate all that child protective services can, and should, and ought to be doing more of and better of. But the system of child welfare in our country is broader than CPS in terms of responsibility for the welfare of children. Do you feel that in your reviews you are able to make recommendations that are cross-systems? We hear "systems change" and I think most public view this, they focus in on CPS as "the system" needing to be improved, whereas it is a much larger shared community responsibility cutting across multiple systems. Do you feel that level of cross-systemic review, recommendations, accountability for improvement is happening?

Miller: [03:04:04] In terms of our statutory responsibilities it hasn't happened to date, but the recent changes to our governing statute will allow us to do that with regard to legal and medical professionals and so on. So we are certainly pleased that is going to happen.

Persky: [03:05:02] There are those six entities that exist in the state, so the OFA, we're specific to DHS and can certainly affect DHS practice. We do have an

interagency agreement with the courts and the State Court Administrative Office to share our reports with them, and they review it. But things like the child death review and those kinds of things that really can have all systems come together and make recommendations very broadly; we are a part of that. And the trends that we see in our review, and the skill sets that we think need to improve around the state, we can certainly inject them into those arenas too, as far as making recommendations and having a voice in those arenas. Sometimes all the systems working together have that kind of broad change.

Dreyfus: [03:05:51] So on the safe sleeping ...

Chairman Sanders: [03:05:52] Commissioner Dreyfus, we're going to have to continue. Thank you very much to the panel. This again was very informative and hopefully all of you will be around because I'm sure there are some additional questions I know that people have some individual ones, as do I. So thank you very much for taking the time and for the wonderful presentations.

We're going to make a slight adjustment in our agenda and we're going to take the opportunity to bring up Representative Dave Camp, who is one of the champions behind the Protect Our Kids Act. Representative Camp represents the Fourth Congressional District of Michigan and serves as Chairman of the U.S. House of Representatives Committee on Ways and Means, helping set the nation's economic health care and social welfare policies. His committee has sole jurisdiction over tax policy and oversees tariff and trade laws, Medicare, Social Security, and welfare and unemployment programs.

Representative Camp was born and raised in Midland, Michigan, and his signature issues include reforming health care to focus on wellness and prevention, expanding access to quality, affordable health care through tax-free savings accounts, and protecting the welfare of our nation's children through family-focused foster care and adoption programs. We thank you for your wonderful tenure in Congress. Thank you very much.

Rep. Dave Camp: [03:07:18] Thank you. [*Applause*] Thank you, very much, Chairman David Sanders, for all your hard work, and I am really anxious to hear more. I was lucky I got to hear a bit of the testimony and some of the questions, and I really just wanted to see some of the steps the Commission is taking first-hand, so thank you for letting me come and thank you for altering the agenda to do that. I also want to thank all the members of the Commission for bringing their expertise to this really important issue.

I see that my colleague, Sandy Levin, is here, a ranking member of the Ways and Means Committee, and I want to thank him also for being part of this effort. This bill came from a bipartisan product of both parties, passed by members of both parties. I have a number of friends on the panel as well. I see Bud Cramer left already. He and I

got elected together, but Cassie Bevan is here, who is a former member of the Ways and Means family, and obviously her background in welfare and family issues is well known. Also, I got to visit with my good friend Maura Corrigan, who I know. Thank you for letting me jump ahead on the agenda. I really appreciate that. But her service to Michigan, as you all know, has been tremendous and obviously she has a recent strategic plan for helping the disabled go to work, which I obviously support all those efforts and want to continue to be part of that.

Obviously the status quo is not acceptable for any of us here, and that is why we are all here in this room. So in October of 2010 I asked the GAO to investigate this issue of child deaths from abuse and neglect, and specifically focusing on the accuracy of the data that states have and how they collect it. Nine months later they reported their findings, and they did that at the Human Resources Subcommittee of the Ways and Means Committee. That was in July of 2011. They said that many more children died from abuse than are officially reported, states have difficulty collecting accurate information on the problem, and also that existing data is not synthesized to really give a full and accurate picture.

As well, many government agencies, including child welfare, health, education, and law enforcement, they are involved, and obviously the rules and the disparate organizations and data sharing hinder the ability to coordinate in this area. So working on a bipartisan basis, we drafted a bill that would establish a Commission to look at this issue in depth and obviously develop recommendations, and in January of 2013 this proposal became law.

I appreciate and want to commend you for the deliberate and careful focus you are giving to this problem and defining it correctly, as well as your field hearings around the country and casting as wide a net as possible to really get some innovative ideas and approaches that are being used around the country that might help us reduce these tragedies, and that is ultimately the goal of this Commission.

So I think we have a real chance here to make a difference, after hearing about the positive work that is happening both with the Commission and at the state and local level, and I actually had an opportunity to read a lot of the background materials. Some really good work has been done, and some really thoughtful articles have been written. I know some of the people that have written those articles are before you today. So I just want to say that we do have a chance to make a huge difference here, and I think that your work is really taking steps to change the status quo and figure out what works, and ultimately to give some of the most vulnerable children a real chance in this world and at a life, and that is really important work. So I want to thank you for what you are doing and commend you for that, and I really appreciate you giving me an opportunity to speak here for a few minutes. I see my former colleague, Bud Cramer, is back, so he is hard at work as usual.

Anyway, thanks again and sure appreciate it. Thank you, and I'm glad to see Sandy is here as well. This shows you just how important we both think this is and how grateful we are that you are taking your time and accepting the appointment you got to be on a Commission to do this.

Thank you.

[*Applause*]

Chairman Sanders: [03:12:05] Thank you very much. Chairman Camp, for your personal interest in this, and I know that this is an important legacy issue, given the tenure of your time serving in Congress and on Ways and Means, so thank you very much for the opportunity you have given all of us. And it does seem a great time to bring Representative Sander Levin up to the stage too for remarks.

Representative Levin has been a representative since 1982, and he represents Michigan's 9th Congressional District, which includes Macomb and Oakland Counties and spans from Lake St. Clair to Bloomfield Township. He is a ranking member of the House Ways and Means Committee, which has jurisdiction over all of the areas I mentioned before, and he has served on four of the six Ways and Means Subcommittees. Thank you very much, Representative Levin.

Rep. Sandy Levin: [03:13:09] Thank you, and I'm very glad to be here. And I want to join you in congratulating my colleague and the Chairman of our committee, Dave Camp. Dave, your interest in this goes back, I think, from the time you didn't even have any kids, and you are the author of this legislation.

I've had a chance to serve on the subcommittee that has jurisdiction over these issues, and I think Chairman Camp would agree that we've wrestled with these issues for a long time. We have had difficulty at times really getting a handle on them.

I think we have had difficulty really grabbing a hold of these issues because I think for almost all of us in this country child abuse is difficult to understand. To try to grasp abused children is a very, very difficult subject, I think, not only emotionally but intellectually. And I think that makes the work of Chairman Camp and others especially important because when a subject matter has immense separation from one's own understanding I think it means that we have to call upon others to help us. That is what you are doing. Because the data are pretty startling, the number in the hundreds of thousands in this country who suffer from child abuse and the number of deaths and the fact that there is a need for services; according to HHS, as I understand it, and I tried to go through some of the materials and understand it, about 40 percent of the kids who are involved with substantial cases of abuse or neglect do not receive any services.

In the health care bill we set up, as you know, some provisions for additional home visiting programs, and that program will elapse in March of next year unless we act.

So let me just say a few words, because I decided to consult an expert that I am now related to. She referred me to a paper that was done in 2011 by the Department of Pediatrics in Cincinnati by Dr. Ammerman and others. It turned out that he served on the panel at NIMH that my late wife Vicki served on and that David knew well. She served as the administrator of a peer review panel on child mental health and development. I was referred to that paper by Dr. Pamela Cole, who served on the panel with my wife for a number of years before Vicki retired and passed away.

I consulted Pamela because two years ago—she was a good friend of Vicki's and that's how I came to know her—Pamela and I were married, and she sent me this paper that I tried to understand. But I think the bottom line was, as I read this study, that as you look at these programs, including the home visiting program, there is really a need for expert interventions through therapeutic interventions. Home visits by themselves often will not be enough.

So I thought I would do one other thing, and let me just mention it before I visit. I know this is of immense interest to you and to the Chairman. We have wrestled with the issue of appropriations for child mental health and services. I was on the Human Resources Subcommittee for a number of years, and I think we always weren't quite sure how to proceed. So when I looked at the appropriation and budget figures it struck me, and Pamela did refer them to me, that in terms of the adoption services and the foster care services we seem to have a very large appropriations, but the appropriations under the titles of Child Welfare and Safe and Stable Families, that is a very, very small portion of the overall appropriations. And so I just wanted to suggest, based on what Pamela said to me, but also looking at these figures, I would think and I think the Chairman would agree, that it would be within the purview of this Commission to look at how well we're doing in Congress in terms of the apportionment of resources and whether there is enough help within the appropriations that targets those families and those people who are very much in need of services. Because I think, and this is usually true, that there is a need for depth within services as well as the kind of broad expanses.

So I leave, and as you know David is retiring, and I think to you, Mr. Chairman, I think one of your many legacies will be your deep concern for the children of this country. And I hope, as you leave, everybody will applaud your dedication. You've been a leader in this and I think when we read figures like hundreds of thousands of kids subject to child abuse and thousands to death, I think the answer is that we have to pay attention to the work of Chairman Camp and others.

Thank you very much.

[*Applause*]

Chairman Sanders: [03:20:46] Thank you very much. Next, I'd like to see if any of the Commissioners want to make any comments before Chairman Camp and Representative Levin have to leave, or any questions.

Rep. Camp: [03:21:11] I had one question I wanted to ask for a discussion point, if we have enough time. I know that we, in Michigan, use multiple sources of data to collect information, and I know you heard from some people today who actually analyze and collect this data. I wondered if, in the hearings that you're having, are there any themes that are emerging or any testimony in other hearings that are similar to what you've had? I am interested in that. I don't know if Sandy has any questions on that. Because I think there really is so much data out there, and really getting the data to work for us in the way we need it to, I know that is what you have been doing. And I know it is early, I'm not asking for any final conclusions, but have you seen any sort of common threads that might be interesting for Sandy and me to hear?

Chairman Sanders: [03:22:05] Commissioner Covington, go ahead.

Covington: [03:22:09] I think one of the common themes around data, and I want to thank you first of all for Commissioning the GAO study because they spent a whole year trying to get to the bottom of it and I really appreciate it because I think it is something that all of the states wrestle with, but certainly a common theme and not much has changed since the report came out, because we still have a lot of work to do. It is that disparity between what you are seeing through different reporting systems and what ends up in NCANDS has been a theme in every state that we have visited, and how to figure out how to make improvements on the fatality reporting in NCANDS, or if that is even where the ultimate official report needs to be. I think it is going to be something that the Commission is going to struggle with. We have more sessions this afternoon, I think, that are going to try to pinpoint what we have been listening to for the last several hearings we've had that will help us sort of hone in on some recommendations to try to really get some clarity as to how to better accomplish stuff, especially as you get into the AFCARS cases.

Chairman Sanders: [03:23:08] Mr. Petit.

Petit: [03:23:09] Yes, I'm Michael Petit. I think a common theme that we are hearing is that the magnitude of this problem is bigger than we thought. That there are millions of children reported for abuse and neglect each year.

I think a second thing that we're getting is the competency, commitment, and knowledge of the states that have been presenting to us has been of the very highest level. On the other hand, it does not appear that the resources necessary to address these problems match the level of awareness and concern that is going on. That the child welfare field, which is broadly everyone in this room and across the country, it is just seeing too many families that are not receiving services. But I think I'm underpinning what we are hearing throughout this is that the social safety net that

welcomes children onto the planet, that enables parents to properly care for their children has been corroded, and there is a need to look at that in a broader systems—policy, political, cultural and economic—way. Then the outcome of that failed safety net is why we are all here now. It is that families are not prepared, in many cases, to raise children in a competent kind of manner.

Chairman Sanders: [03:24:20] Commissioner Dreyfus?

Dreyfus: [03:24:21] I want to thank you for recognizing the issues around child welfare financing in our country. And I would tell you as a Commissioner, in presenting these hearings, one of the things that is really clear is that we are not putting enough resources into the front end of our system, the quality of our child protection system and the quality of our earlier intervention and responses to families.

So I can't help, as a Commissioner, but go through this process and see that there is a parallel here to the need for child welfare finance reform in our country, sooner rather than later, as it relates to what is a very deep-end funded system that really is not consistent with what I think everyone around the country is telling us is critical; a quality child protective system that is able to be responsive for every child, every time, and the kind of services and support that can be used early on. Yet we have a federal financing system that really doesn't allow that to happen. So I really appreciate that you've brought that up.

Chairman Sanders: [03:25:31] And Representative Chairman Camp and Representative Levin, I just want to mention that I think there are a couple of themes that we've heard that are consistent, and I think each of the Commissioners have referenced some of them: the issue of the identification of a fatality due to abuse or neglect and the implications of that has emerged in a way very similar to the GAO's finding. And I think that we have heard the issues with whether something is actually a child abuse or neglect fatality and/or is it something preventable? I think we have heard some consistent practices that suggest there are deaths that are preventable, but those practices aren't being utilized widely and they seem to impact pockets but not the entire population. There are issues with sharing of information that seem to be a prohibition to actually working together and implementing some of the strategies that seem to be effective, and that seems to vary from state to state, and how information is shared across states, as well as, on a macro level as well as on a micro level, one of the areas that we've heard is a major theme.

Chairman Sanders: [03:26:57] Commissioner Cramer?

Cramer: [03:27:02] And to Dave Camp and to Sandy Levin, I want to thank both of you for your dedication to this issue. Dave, we will miss you in the halls of Congress and we wish you the best.

I want to just briefly comment that the frustrating part about what we are hearing is that we are talking about some of the same issues we were talking about 20 years ago. And while it is, to some extent, a matter of funding, we have just got to be smarter about how we are spending money, how the teams are communicating with one another. This is not just about the child protective services system, this is about law enforcement, this is about prosecutors, this is about medical examiners, mental health folks, across the board. Those folks need to continue their wonderful pockets of strength around the country. Those frontline teams are reviewing cases together and dedicating themselves to making the system work better, but that is not going on everywhere.

Yes, we want to improve what is happening, and obviously just adding money to it won't necessarily do that. It might help, but we want to also improve the systems that are involved. And we would be interested in your points of view, what product would you like or have you in mind from a Commission like this that could be more than just another report on a shelf somewhere?

Rep. Camp: [03:28:33] You know the charge of the Commission is to review data on fatalities, prevention methods, the adequacy of the current programs, which would fit sort of what some of the members have been saying, and then how do we reduce deaths from abuse and neglect? I've read some of the materials and some of the presentations that are coming this afternoon are going to be on data collection and some of the systemizing of that. There are some innovative things being discussed and methods on how to do that. One of the things that I heard earlier is uniformity, but what do you go to then? And I think that is one of the areas the Commission could be very helpful on, because obviously you want to try to reduce these numbers because we have got to do better. It is a very difficult problem. It was a long time ago, but I used to practice law in this area, and it was so difficult to make that determination, not just what is abuse and neglect, but when do you intervene and how do you intervene, if this is going to be a successful family? The Adoption and Safe Families Act was to really recognize there's a point where you aren't going to continue to offer services and you are going to put this child in a safe and loving home. But this is about what analysis to do. This is the caseworker that is actually going to go see the family. What do they go through, and then is that consistent? And then the interagency. I mean really, along the lines of what GAO found, that there are many data points, there are many agencies and local government units that are involved in this, and law enforcement, the courts, caseworkers, and professionals. How do we find a way to get this information so that we are really making progress here, because we all agree this is a problem that is way too prevalent.

Rep. Levin: [03:30:36] Well, I would just add that I would urge you to be blunt and direct. I don't think you should hesitate to say it the way it is. You know, all my married life the word "prevention" has been the most used by my spouses, and we have trouble preventing and we tend to pour more into resources after the fact. Also,

if there are differences I think you should express them. You know, it's not related, but I've been listening with kind of disbelief about the issues of child care in other countries and the most recent reports, and I think the lesson is that it is totally unacceptable to duck these issues. So I think if you can take the charge that was essentially given to you by the Chairman of our committee, Mr. Doggett, to set this up that I think the best way to meet the charge is to just meet it with total candor and not worry if you step on some toes, because I think some toes need to be stepped on. I think there are so many people devoting themselves, but we often don't have good data. We don't even have definitions that everybody accepts. But even more so, I think there is a state of denial in our society, and maybe naturally in every society. And I think, David, you set this up to counteract denial. And so I think the more you take on our denial, the more you will serve the purpose of the legislation. So we wish you well.

[*Applause*]

Chairman Sanders: [03:33:00] Thank you. Thank you very much. We are going to have our final speaker before lunch break, Maura D. Corrigan, who is the Director of the Michigan Department of Human Services. Thank you, Director Corrigan, for giving up your earlier time. We look forward to hearing from you. Director Corrigan has directed the department since 2011, and prior to that served as a judge of the Michigan Court of Appeals and Justice of the Supreme Court for 19 years. Director?

Director Maura Corrigan: [03:33:51] Thank you and good morning members of the Commission and members of the audience who are interested. Michigan is the eighth-largest child welfare system in the United States of America. I am very thrilled to welcome all of you to metro Detroit today, and on behalf of my boss, Governor Rick Snyder, and the wonderful colleagues of mine who you have met this morning and will meet later this afternoon from our department, I say welcome and thank you for the tremendous work that you are doing. I also thank my wonderful friend, Dave Camp, and Congressman Sandy Levin and their colleagues for sponsoring this legislation and looking at a very difficult problem. Nelson Mandela said, "There can be no keener revelation of a society's soul than the way in which it treats its children." The work that you are undertaking, and the recommendations you make, will be good for our nation's soul and will be life-changing and life-saving for many children. So I hope the presentations that you hear from the great state of Michigan and that you have heard will aid your deliberations and advance your mission.

I want to mention three areas and discuss them this morning before lunch. First of all, I'm asking you to assist in stabilizing the top leadership of child welfare in this country, and I'm advocating for something you have already mentioned, and that is flexibility in federal funding of child welfare. The next thing I will talk about is the progress that I believe our state of Michigan has made in addressing and preventing child abuse and neglect fatalities. And finally, I want to talk about what I hope my

children put on my tombstone, the words: "Tear down the silos." What are we doing in Michigan to tear down silos and build collaboration?

First, let me talk about the stability of child welfare leadership. What I believe is that progress on child safety depends on stable leadership. An overriding truth is that strong leaders who hold others accountable achieve results. But in this country, the top leadership of child welfare is a revolving door, whether that leader is called the director, the commissioner, or the secretary. At the end of this year, I will have led the Michigan Department of Human Services for four years. I came here at the governor's invitation after 19 years as a judge with responsibility for child welfare, child support, and a particular interest in children who had died in the system. As a judge, you are known for your long tenure. As the leader of child welfare, it is the exact opposite in this country. In Michigan, serving four years is a record. No one in the last 40 years has served longer than I have. And I was privileged early on in my tenure to attend a seminar conducted through Casey Family Programs and Dr. David Sanders with other top child welfare leaders and learned that the average tenure of a child welfare director, commissioner, secretary or whatever you want to call it in the United States of America is 18 months. What can you do in 18 months? Do you even know which way the bathroom is in 18 months? You can barely get your bearings in 18 months. And the principal reason disclosed at this meeting why child welfare leaders leave in the country is because of media accounts surrounding child deaths that drive them out. That is the conventional wisdom that top child welfare leaders believe. Many of these media accounts call to fire the child welfare leader, as if bringing the head of the child welfare leader will fix the system, something you and I know is not true.

One of the reasons that these child welfare leaders believe that they cannot speak is because of CAPTA confidentiality provisions that threaten child welfare. So I hope that you will take a look at confidentiality provisions in CAPTA and what they do to muzzle people from speaking out who hold similar positions to me in the country around the circumstances of a child death. I think that is significant, and I further would advocate to you that you think about studying the stability of child welfare leadership in the country because you can have all the data in the world, and data does drive everything.

But who is the driver? A human being. A human being has to get results. Earlier in the day you were asking questions about, "Well why isn't this changing? Why aren't we getting results here? What is going on with all these studies and reports? Who *is* going to be responsible to make change if it isn't top-down leadership?" And when they are moving on after 18 months, you cannot expect that there will be people who will hold others accountable and get results. These are punishing jobs, and some of the punishment is that in spite of the legions of dedicated people who care so deeply, and you have heard from them all over the country, that the system is breathtakingly

convoluted. It is landscaped and dotted by funding silos and tangled up by competing and exacting federal reporting requirements.

Our focus nationally needs to be not on process for the sake of process, it needs to be on meaningful standards, not a laundry list of outcomes. Even when we make progress in Michigan, and sometimes great progress, we fail. According to ACF, and I no burn on Wade Horn, according to ACF, Michigan failed on the CFSR on absence of abuse or neglect in foster care because we were just shy of the federal standard of 99.39%, four-tenths of a percent off on the absence of abuse or neglect in foster care. There is something dramatically wrong when every state in the union cannot pass the CFSR. There is something wrong with what we are doing.

Similarly, in the United States of America, 30 states are involved in class-action litigation around constitutional claims principally about child safety in their states. In my state we are a relative newbie in class-action litigation. Ours started in 2006. We have a consent agreement. We have 210 commitments in our consent agreement, and every reporting period, every six months, we turn in 150 to 160 measureable deliverables to our federal monitors, all reams of data that our staff is collecting that taxpayer dollars are being spent on as they are with CFSRs, as they are in all these class action lawsuits. So we are spending our time, our money, and taxpayers' dollars to do this. Commissioner Cramer, when you ask, "Why isn't it getting better?" part of the reason is because we are focused like a laser on our auditors, on our monitors, on our reviewers, on answering CFSRs, on answering and defending federal litigation, and you need to ask at the end of the day, "Are we even measuring the right things?" You heard a lot about the right things to measure this morning. You did. We need to ask, "Isn't there a better and a simpler way to achieve our objectives?"

In the child welfare arena, we lack the power of the purse. Generally, we are in bondage to the rigorous dictates of a myriad of federal funding streams. And we are captive to the findings of federal auditors and monitors. You Commissioners have the ear of the President and of our wonderful Congressmen, and you can ask for flexible funding in the states. Like Justin had to say this morning, like Nancy had to say, like all of our wonderful panelists, "Where are the needs?" Give us the power to have flexible funding so that we can go to where the most critical areas are in order to protect children in this country and eliminate child abuse and neglect fatalities. You have the ability to plead for consideration of consolidating disparate funding streams, of getting to a clear focus on outcomes, and you are uniquely situated to articulate a clear vision, and I hope you will.

I'm going to turn to my second area, about, what are we really doing in child safety in Michigan? What have we been doing these past several years? What progress have we made in preventing and addressing child abuse and neglect fatalities?

I want to give you a very quick elevator speech on what Michigan has done in the past few years. First of all, 10 years ago when I started doing this work, our average daily census of children in the foster care system was 19,000. Today that number is right around 13,000 for our average daily census. So we are removing fewer children, as you have heard, and we are stabilizing them in their homes with services in many cases. Happily, I will tell you that we are also moving children to permanency much more quickly. Last year we broke all the records we ever had; 89 percent of the children available for adoption in Michigan went to permanent homes in the same fiscal year. That meant we only had 250 children in the whole state without identified adoptive parents. So we are moving the needle there. You have heard of, and I thank Commissioner Dreyfus for her work on our performance-based funding task force. We are moving there. We have continuous quality improvement for the first time within the department, so we can check internally on how we are doing. We have right-size caseloads. When I did this work at the Michigan Supreme Court we had, in Wayne County alone, CPS workers with as many as 70 cases on their case loads. Our case loads today meet the national standards that you care so much about. CPS workers generally have 12 cases. Foster care and adoption workers have 15, and 100 percent of our workers are getting the training. Both new workers and supervisors, and we are doing it not just for the newbies, but also on continuing education. We have the agony of MiSACWIS, right? We rolled that out in April, again, a dream, and we have 7,000 users on the system, so they are learning how to deal with the new computer system. But from my standpoint as a former judge, I wanted everybody on the same platform—courts, private agencies, departments—and ultimately it ought to give us the data that we need to capably run our system.

Let me talk about child abuse and neglect fatalities for a minute. First, a few words on helpful state legislation, and I can delete most of these remarks for you. Because you heard about safe sleep from Colin and that piece of legislation, you heard about the OCO from Tobin Miller, the new legislation around children's ombudsman. I want to underscore the importance of that, because what that new law will do will let our ombudsman, as an external reviewer, look at all the systems involved in a child death. Previously, the ombudsman would focus on our department and focus on private agencies, but now they will look at all the potential players, from courts, lawyers, and everybody involved in it, so they will have much more power to investigate a child fatality then they did previously.

But I want to talk for a moment, too, I was shocked to hear Lora Weingarden tell you that we need a statistical child death registry. We have one. She doesn't know about it. So we did something bad there, ladies and gentlemen. But in 2011 we went to our legislature and described sort of a Michigan version of what you are hearing from all over the country. The disparate groups that we have who are tracking child deaths, and we didn't talk well enough with one another at that time. And as a Justice I was shocked that even in a case where the courts had jurisdiction, we could not get anything on the reasons that the child had died. So we went to our legislature and

asked them to take all the different five agencies that you have heard this morning and to allow there to be a central registry and a central place for information, and that passed finally, in 2011. We wanted there to break down the silos, and you have heard a lot today about the increased collaboration that is occurring in Michigan, and that is a consequence of a change in law.

One area of law that I want to mention that really has affected the safety of newborns is our safe surrender law, and under that law in Michigan, 150 babies have been surrendered. And so those are 150 children, I can tell you, who are alive today because of safe surrender legislation in Michigan.

I want to move quickly to the next part of my remarks, on what we are doing on child safety and on collaboration. We understand that we have to have institutional cooperation and collaboration across the three branches of government, with other departments, with local governments and our private partners. So we launched a standing committee focused only on the issue of child safety in Michigan. What we do with that committee is to identify key safety initiatives that we need. We set goals, we gather in one room all the people who are responsible for implementing these initiatives and we listen to one another, we plan, and we hopefully obtain results. So the work that we are doing, for example, on safe sleep practices is reported on to the standing committee. We have the suicide prevention initiative that Seth Persky mentioned. Why? Last year we had three older youths die from suicide. That is a recurrent, prevalent problem when you measure the deaths of children in the system.

And so what we have decided to do is go after the whole issue of training around suicides. Next April, as a consequence of the safety committee and the work being done, we will be training 500 professionals on suicide prevention best practices. This is a need, we think, and we will be training social workers, law enforcement, prosecutors, pastors, judges, people who would have a tendency to encounter individuals who may threaten suicide, and they will all be at this table. One of the things we need to do is figure out how to fund this initiative. We can fund a two-day conference, but how do we do ongoing training around suicide prevention? And I believe that will move the needle.

And finally, you heard a lot, and I thought Colin Parks gave a fabulous answer on predictive analytics as the key. When I was at the conference that Dr. Sanders sponsored on what was going on nationally and heard what happened in Tampa, Florida on the deaths, that it went to zero, I said, “Stop the works. This is like a cure for cancer. We have to go to this.” We need to move to predictive analytics in Michigan, and ergo you have what we are doing in Ingham County and the tremendous relationship. Now the silo of domestic violence and the silo of child abuse and neglect, and we are doing cross-cutting work now because of what happened with Eckerd, because that is what our data is showing from the analysis of those cases. So we think

predictive analytics is where we need to be going nationally and that you ought to look at that closely.

We are grateful to Casey, again, for helping us in Saginaw County with the Signs of Safety program, and we have seen a 20 percent reduction in the recurrence of abuse and neglect in Saginaw. Again, we think that is better than sliced bread, and we are taking it to Calhoun County and Wayne County this year to train our workers.

Part of what we have been doing in the safety committee, and I thank Stacie Bladen, Seth Persky, and Colin Parks, is training workers specifically on how do you assess for safety? Not on a checklist. Think about what you are seeing in front of your face and what is going on in that house. Is that child safe? Will that child be safe at 10:00 at night tonight, when mom is drunk? How do we train workers to do that? And we have hit 17 counties. So I am thrilled that there is six months of this year where we have had no ward deaths. I think it is wonderful. Maybe that is a statistical anomaly or maybe we are really moving the needle. I hope the latter.

Well, I have spoken and I am interfering with lunch, I understand that. But I want to just finish up with a couple of remarks about tearing down silos and building systems that support collaboration and communication. Government has a very hard time keeping up with the latest in technology or even using current systems to our advantage. In Michigan we have two new tracking systems that I am really thrilled about. One of the things that is overwhelming as a new child welfare or human services leader is the amount of past promises that are out there, the amount of audit findings, and the amount of problems that you encounter and you don't even know about until the new audit report comes out. So our first tracking system is our promises tracking system so that I or whoever is in my chair can know what we promised last year or five years ago. That is a difficult endeavor for a child welfare leader. We will have a new tracking system that helps us on that front end use the most current IT to track all our findings, internal and external, and the promises we have made.

So the Internet turned 25, did you know that? I didn't even learn to email until I was 50, and that was a really long time ago. But the Internet is 25, and a lot of our computer systems in state government are that old. And so the second system that we are launching is going to be in the Office of Family Advocate and it mirrors our efforts to work effectively on child death cases. So we will have a web-based system that is going to allow everyone who is a reviewer on a child death case to have access to a secure online database. So the OCO will be able to get into it, all of the folks that you have heard from today will be able to share information more effectively. We will eliminate duplication and increase collaboration in that way and improve our efforts to handle child death cases more effectively. I think it would be interesting for you to recommend legislation to the Congress that would incentivize building IT systems

around the technology that our clients and our caseworkers actually use, instead of the old-fashioned systems that we have at work. Could you do that?

For many families, including many of our clients, they get their information from smartphones. We are not there, and we ought to be. Let's make sure that we build our systems in line with what is actually going on in real people's lives. We had this great hockey star, Wayne Gretzky, and he once said, "I skate to where the puck is going to be, not where it has been." And I think we ought to keep that in mind when we are thinking about the collaborative systems that we build and the IT that we need to make the system work.

In conclusion, I have one last plea for you. Like Congressman Camp and Congressman Levin, my plea is that the reports that you issue don't sit on the shelf or get buried in partisan gridlock. The issues here, as they point out justly, are ones around which the right and left can unite. I hope, though, I hope that whatever goes in your report, that you will take the best practices that you are learning from the country and share them with all of us who are leading child welfare organizations around the country, maybe in face-to-face regional summits and webinars, however you can do it. Because I learned things here today about Michigan that I didn't know. And I know I need to do a summit on my state on this topic, but I think that it would be really helpful to all of us who do this. We are, after all, human beings not gods. And we don't know everything and there are new people who come on, so we know that we have improved but we must do more. All of us, in concert with the federal government, have to be vigilant and relentless.

We pledge that we will continue to improve our system in Michigan, and we are committed to reforming what our great basketball coach at Michigan State University, Tom Izzo, says: "Here is how you build a winning team. First of all you stabilize, second, you sustain, and third, you build." And that is how I think about what we need to be doing at the Department of Human Services, and what we need to be doing in the country, to stabilize leadership and allow those leaders to sustain, and build, and hold people accountable. I want to quote, because we are in Michigan, the home of General Motors, the late, great President of General Motors, Ed Cole, who once said, "We want to kick the hell out of the status quo."

Thank you so much, Commissioners. I'm so glad to be with you.

[*Applause*]

Chairman Sanders: [03:59:50] Thank you very much, Director Corrigan. We are going to go ahead and take our lunch break on that high note. We will ask you to come back for some questions after the lunch break.

Corrigan: [04:00:01] Sure. All right. Thank you so much.

Chairman Sanders: [04:00:03] Thank you very much. We will break for 30 minutes. We will reconvene at 12:30.

Lunch Break [04:00:07]

Chairman Sanders: [04:46:23] We'll get started in just a couple of minutes with our afternoon panel. Director Corrigan will be here all afternoon, so we will have the opportunity to ask questions of her after this panel.

We have a group of presenters who are at the top of the field in understanding data collection related to child fatalities due to abuse or neglect, and particularly looking at how we can improve to better affect practice and policy.

I'm going to turn it over to Dr. Rachel Berger, who provides support to the Commission on research, to introduce the panelists, and she also is going to facilitate the discussion.

Dr. Rachel Berger: [04:47:39] We chose these four speakers because of their work in solutions, and one of the things that had come up previously as we discussed all the problems with counting and all the challenges, but what are the potential solutions that are available? So we chose these speakers because all of them have worked with very specific systems that may provide some potential answers.

So our first speaker is Amy Slep; she is a professor at New York University, and her experience is with the Air Force data set. And what we are going to do, we have actually successfully have permission to use it and demonstrate it. So after they all speak, we are going to demonstrate a case and how the Air Force system would use this type of case.

Our second speaker is Patty Schnitzer, who is at the University of Missouri, and she is going to talk about some of her work, again, with other systems of counting.

Steve Wirtz is from California, and he is the Chief of the Injury Surveillance and Epidemiology Section in the California Department of Public Health, and is going talk about California's death review system and process of data collection.

Then finally, Vince Palusci; he is a professor in the Department of Pediatrics at Bellevue and is also going to talk about different potential solutions for data collection.

So they are each going to speak for 12 to 15 minutes, then we are going to give a couple of scenarios and show how these different systems might react to those scenarios, and then we will have plenty of time for questions.

Dr. Amy Slep: [04:49:22] So hi, I'm Amy Slep, and thank you for the opportunity to present to you all today. I'm sort of humbled at the thought of the challenges that you

are tasked with resolving, and I'm very hopeful that some of the work we've done may offer at least some ways forward.

I just want to acknowledge all the work that I've done has been in collaboration with my close colleague, Rick Heyman, and the work I'm presenting today has been in partnership most especially with the Air Force Family Advocacy Program. We have also collaborated now with the World Health Organization.

Okay, so what we were charged with doing was to develop operationalized criteria for child maltreatment—we also did spouse maltreatment—that could be used in the Air Force. I'm going to present on that today because I think that work is most relevant to the challenges you are facing.

I'll tell you a little bit about how that is being disseminated. I have a couple of screen shots of the decision tree that the Air Force uses and what it looks like, but since Rachel has moved mountains and has a functioning decision tree, I'll skip over those and then give you my recommendations.

Okay, so as you all know, there is no consensus in the field about what constitutes abuse and neglect. There are some general themes that everyone agrees on, but the details are where people get squishy. That's a challenge. If you want to aggregate across data systems, if you want to even know whether the prevalence of maltreatment is going up or down, whether your outreach efforts are being successful and so perhaps the number of cases that are being reported to CPS is going up but that's because of good outreach, so in fact the prevalence, the problem in the population is staying the same. To be able to get at those sorts of issues, you have to have a measurement, a threshold, a criteria that doesn't change, that isn't fluctuating along with other things that change in the system. And the key is that even though we have some uniform definitions that exist for particular forums, those don't translate well to individual decision-making.

And so back in 2002, the Air Force Family Advocacy Program approached Rick Heyman and myself and said, "Hey," (since we were working on developing self-report measures of maltreatment with them), "we have real concerns about the consistency of our maltreatment definition and the way those are implemented in the field. We have active duty members that go from one location to another and something that was okay in one place isn't okay in another place, and that causes problems for them. We have workers who move from one site to another site, and we know that our substantiation rates vary all over the place, depending on who is chairing our decision-making committees. All of that seems to be a problem. Do you think you can fix it?" And we were young and naïve, and didn't really understand, and so we said, "Oh, that sounds like a fun challenge. Sure!" So we set about doing that.

So of course the first step, we reviewed every written definition of any type of child abuse or neglect that was out there at that point. We then developed the simplest—

because this is for real people to use, and making real decisions. So they had to be the simplest operationalizations we could achieve that would allow consistent decision-making.

So just one little word about that. So both my colleague and I have a background in psychometrics, which is developing tools to measure things in people, basically. And one of the axioms in psychometrics is that reliability constrains validity. It cannot be true if it is not consistent. Just because it is consistent doesn't mean it is accurate, but if it isn't consistent it can't be accurate. So if you get on your scale one morning and it says you weigh 114 pounds, and you get on the scale the next morning and it says you weigh 214 pounds, and every day it's a different number, you can be pretty sure it is not accurate. If it always gives you the same number it might be right or it might be wrong, but at least there is the potential for it to be right.

So usually, in psychometrics, the first step is you have to make a tool be consistent, resulting in consistent results, and then you can calibrate it and adjust the threshold or adjust the measurement tools to make it as valid as possible. But you can't consider the issue of validity before you have resolved the challenge of reliability.

So our first step was to try to resolve that issue of reliability. So we had to develop the simplest operationalizations we could that was, of course, consistent decision-making. And then, because the Air Force Family Advocacy Program were such great partners to work with, we were able to conduct a series of field trials, which is really key to getting this to work.

Then we conducted a dissemination trial which was then, "We don't care whether you are a volunteer or not we're pushing this out, we're randomly assigning the way we're training you and setting it up, and we're going to see if it still works as well under those real world conditions."

So how did that all work? Well, the field trials were super-important. I can say that the first field trial, which just with our definitions, did result in a marked improvement in reliability, but it wasn't good enough. And by the time we got to the end of that field trial, you could see how other sources were starting to undermine people's consistent application of those criteria. So in this second field trial, there were slight adjustments to the criteria, but we kept the criteria. We added a structured assessment to try to feed the right information into the decision-making process, and we created a computerized decision tool that breaks each type of maltreatment into specific relevant criteria, and asked the Air Force as a committee, asked the committee, to consider each criterion. So at no point are they being asked to decide if this is an abusive mother, or if this was a neglecting family, they are just being asked very specific criterion-based things, and the computer walks them through that process. That helped tremendously.

So with those three things together and that field trial, and these field trials included thousands of cases at several sites, we ended up with a greater than 90 percent consistency rate between the field decisions that were made and expert reviewers who were listening in and applying the criteria. We then did a dissemination trial where this was pushed out to 41 Air Force installations in the country, and we maintained the same level of reliability. And for that there was a one-hour, web-based training and a quiz that people had to take to be able to then vote. But there wasn't anything more intensive then that.

In the dissemination trial, we were also able to look at the effect of the change in process and the definition on recidivism, because sites were randomized to when they had to implement this. And so we could look at the period when they were using the old system and compare it to their first 12 months of using the new system. And it's not a randomized, controlled trial, but it is a quasi-experiment that is pretty well conducted, and implementing the system cut recidivism in half. And in the military we think what is responsible for that is that the decisions get made and communicated back to the family, so the criteria are then explained to the family. And although many families can't regulate their behavior to keep it on this side of the line versus that side of the line, some families can. And for some families, this improved information was enough.

The other thing that happened is that the leadership in the Air Force and people in all parts of the process had more buy-in into the system and felt that the process was more fair, which we think also helped support the message going back to families that this was important.

And again, these are all substantiation decisions. This wasn't around fatalities, specifically, but this is about there is an allegation of maltreatment and does this go above or below the line, so it would probably need to be adjusted for fatalities.

Okay, so at this point, this decision tree and these criteria are being used throughout the Department of Defense, the entire Air Force has been using it since 2008, and I think all of the services have been using it since 2010. So it is in use at all United States military installations, and the state of Alaska's child welfare system is in the process of adopting the criteria, and then also the criteria but not the decision tree and those sorts of things are starting to be incorporated into medical classification systems. So there is a streamlined version of the criteria that are now incorporated into the *Diagnostic and Statistical Manual*, which is the DSM, which is what mental health folks in the United States use for diagnosis. And we are currently conducting field trials with the World Health Organization on the criteria to see if they'll be included, and they are provisionally going to be part of the next revision of the International Classification review manual.

So our experience suggests that you can reliably determine if an incident is above or below a threshold for maltreatment, that the best decisions really are promoted by using a computerized decision tool or some other aid so that people can break it into pieces and consider piece at a time. Standardized assessment information is very helpful to making those definitions or making those decisions. You will see when you see the tree, when Rachel demonstrates that, that if you don't know the answer, you don't know the answer. So that is still true. In the military this resulted also in the clinicians who do assessments, changing the way they conduct those assessments in those structured assessments.

It is also super important for removing bias to have the decisions be based on specific criteria and not on an overall decision. We saw that over and over. You do need training, but brief training seems to be okay. These decisions are made pretty efficiently. The Air Force monitors how long it takes for a committee to decide cases, because if they take too long the odds of them making the wrong decision go up. So the average has got to be about 10 minutes per incident. And if it gets much longer than that they are often talking about stuff that isn't relevant. And it looks like there is a potential for a system like this to have a preventative effect. So all of our criteria are set up to have people to be able to hang on them a little bit.

There is an act or an omission, and then because this is a substantiation determination, there is a consideration of impact. And because we don't want people to be saying, "Yes, but..." while they are making those decisions, for many of the types of maltreatment there are also exclusions. So if you are throwing a pillow at your 4-year-old and the way it hits him the zipper cuts right below his eye, then there was an act, you threw something at your child, there was an impact, there's a cut below his eye, but that would be considered, as long as your assessment revealed this, it would most likely be considered developmentally appropriate physical play, and therefore it would end up not counting as maltreatment. And so we tried to think of all of those scenarios. The definitions are still somewhat fluid and so that if committees hear cases that we don't think fit in the definitions well, that comes back to us and we try to figure out if we need to adjust things.

And the decision tree works very efficiently, and so it asks the fewest number of questions it can to get to a determination. So once it's decided, then it doesn't keep considering other ways of getting to the same decision.

Rachel is going to show you this so I'm going to skip it, but these are screen shots of the decision tree.

So then just some recommendations. I would recommend that if you want to be able to... because right now all of the different systems and states use different definitions, and in conversations with my local county child welfare office, the different teams in that county use different decision rules, and the different people

within the teams use different decision rules … that if you want to be able to have apples and apples, you have adopt a single set of criteria that makes classifications at whatever level you want to count at. We can't assume that everybody is going to make decisions the way you want them to. The tiny differences in the wording matter. I was saying to Rachel before, that was really the point of the field trials, was to try out different language sets and see which ones trip people up and which ones don't. It's great to have a lot of input from a lot of people, but in the end the criteria can't be written by 73 people because they will not result in consistent decisions that well. Decision tools help remove bias. Deciding criterion by criterion, I think, is essential =— and then you push out to the people who gather information the kind of data elements that you need, and ultimately that may have the effect of promoting change and consistency downstream from where those decisions are made. So in the Air Force these committees are formed by Family Advocacy, which is the equivalent of child welfare, but also it includes cops, it includes medical providers, and once everybody gets used to the criteria that are involved, it changes the kind of information they make sure they are getting about their cases.

Over time I think that if ultimately other systems adopted the same thresholds the national system was using, then you wouldn't need to have somebody revisit those decisions. But I think it is critical to have one place where people are deciding if things are apples or if they are apples, oranges, or bananas.

Dr. Patricia Schnitzer: [05:06:30] Thank you, really, for this opportunity to speak with you today and share some of my work. I am an epidemiologist, and I've been working on defining and measuring child abuse and neglect for the past 15 years, and my work is, I have a particular interest and a particular focus on child neglect. You've heard a lot. I think the first panel this morning set up a lot of the questions and background that I've been dealing with also in my work. I think in your packet you have a brief summary of some of my work. I'm going to even more briefly summarize that and then go straight to conclusions and recommendations, and I'm going to move fairly quickly because the people who know me know I have a lot to say and I'm going to try and give you as much pertinent information as I can.

So briefly, I'm going to talk about a summary of a couple of projects I've worked on and then present conclusions and recommendations that I think are pertinent to your work on the Commission. I said I'm an epidemiologist and all my work has been focused on using a public health approach to define and measure child maltreatment and child maltreatment fatalities, so I'm going to give you the "CliffsNotes" version of a public health approach, and in public health, prevention is the goal. The goal, as opposed to where you have law enforcement or child welfare agencies, where there are social or legal consequences for making a determination on whether it is child maltreatment or not, the public health approach really focuses on prevention and what we need to know in order to prevent those injuries, illnesses, and fatalities from happening in the future. It's not about punishing parents or no legal consequences

there. It is also a population-based mechanism to improve estimation of child maltreatment fatalities. By "population-based," we mean any child is eligible to be included and the universe of children is the denominator and the maltreated children would be the numerator. So you can calculate proportions, as opposed to, in child welfare agencies, as Steve Yager pointed out, they have an excellent system for defining child maltreatment here in Michigan, but they still will only capture those deaths, and define those deaths, and measure those deaths that are reported to them. Whereas in public health we want to be able to capture, identify, count, and measure deaths that are not reported necessarily to child welfare, or maybe not identified by law enforcement, not prosecuted by the prosecuting attorney. So we will hopefully include all those children that might be missed by individual systems or agencies. Also, a key element of the public health approach is to collect and analyze information on the circumstances of the death. We want to know how many but we need to know about what happened with that child? How did that child die? Is that maltreatment? What are those circumstances that led to that death? Because only from knowing that information will you understand the risk factors and are able to document the risk factors. You have heard a lot about predictive analytics. Well you can't do predictive analytics unless you know the circumstances of those deaths and how those children are dying, and those risk factors are essential for developing effective intervention and prevention strategies.

Also, the collecting and analyzing this information facilitates monitoring trends over time, so if you can get a consistent definition and documentation of child maltreatment fatalities and use that consistently over time, then you can monitor your trends. Is it going up or down? If it is not just the definitions changing or now they are counting better than they used to, but they are counting the same way and then you know whether it is going up and down, and that information is critical to be able to evaluate those interventions that you develop. So if you can consistently count and you are doing a good job over time, time, time, and you've developed these interventions and you don't see numbers going down, well maybe those interventions aren't working. If you see numbers going down and you can be certain that you are still counting the same way, then you can be more confident that those interventions are having some impact. So that's my plea for the public health approach and the primer for you all.

I've done some work on definitions. One of the things I was asked to talk about was the CDC public health definition for child maltreatment surveillance. So a number of us, Commissioner Covington, Drs. Palusci and Wirtz, worked together about 12 years ago on a CDC-funded project, and one of the goals of that project was to develop and help the CDC, the Centers for Disease Control and Prevention, develop a public health surveillance definition of child maltreatment, and we did. We helped them, they developed the definition, and I'll say no more about that. But then a couple of years later they awarded a contractor, RTI, international consulting, Research Triangle Institute, to actually develop model surveillance systems in three states. California

was one of the states that participated. Michigan was another state that participated in that process. I was involved in that as the technical expert in the definition of child maltreatment. So as part of the overall evaluation of that project, we evaluated the application of the CDC surveillance definition and we created five scenarios that the state multidisciplinary teams went through step by step and classified based on the CDC definitions. And the results of that are that with the guidance of clearly stated definitions, professionals from different disciplines can and will reach consensus on whether the circumstances of death meet the definition or not. Regardless of whether their agency or profession would classify the death as maltreatment. So what we heard was, "Yes, this meets the definition, but we wouldn't arrest this person." "Yes, this meets the definition, but we would not substantiate this drowning death as child neglect because..." whatever. But yes, it meets the definition that you have laid out. And so you can have an objective definition, and I think this is also what Amy is seeing too. Is it takes away people's need to agree, because every agency, they have their legal mandates, they have their policy reasons, they classify these deaths for their purposes, which are important but they are individual and not everyone is the same, and they aren't all going to agree.

But we found that if you give them the information to classify, they will classify using those criteria. And I also believe that behaviorally focused, clearly stated conceptual and operational definitions will be widely useful, objective, and remove a sense of judgment when applied. And I said "behaviorally focused" because there are some that are focused on behavior of the parent or needs of the children, they aren't all focused.

So I said I have a special interest in neglect. It is the thorniest issue. You heard that this morning, "Is this drowning death neglect?" "Is this motor vehicle crash death neglect-related?" We know neglect deaths are woefully underascertained. Some of the reasons were described this morning by Drs. Mohr and Hunter in the first session, and others this morning.

I worked on a project with Commissioner Covington, and our goal was to attempt to characterize some of the challenges faced by multidisciplinary child death review teams in classifying a death as neglect related or not, because we have worked with child death review teams and we knew this first-hand, that they have these discussions. And you talked about cultural differences: "Well, in the rural communities the kids are doing this, but in the city they would never do this." So we wanted to be able to document and quantify what these issues were, and what we found was that reaching a consensus of a multidisciplinary group was challenging because of the different agency definitions of neglect, because of lack of standards of minimally adequate care or appropriate supervision, especially for very young children, changing social norms, and then there are four attributes that always are thorny and always pop up: poverty, age of the child, intent, and chronicity. You heard a little bit about that this morning.

Our final conclusion was that team members often hesitate to classify a death as neglect related without evidence of a pattern of neglect or some evidence of intent to neglect. It is very hard. Those are the clearest cut cases, "Yes, they did this before, and before, and before, and now this child is dead." Then it is a little easier for them to say that was neglect related.

I am working on two projects I'll summarize very quickly. Currently I am working on a project where I have linked—I didn't actually do the linkage, but data were linked—child death review data from the National Case Reporting System from nine states were linked to the death certificate data for those nine states, and this is deaths of children age 8 days up to 5 years of age, so the youngest children, where child maltreatment fatalities are the highest rates. One of the primary goals of the project is to develop a strategy to make death certificates better at identifying child abuse and neglect-related deaths because we know that they are one of the worst sources of child abuse and neglect-related deaths. You heard some of that from Dr. Hunter, the medical examiner, and there are some reasons for that. But we want to make them better, and the vital statistics program, the Mortality Statistics Branch at the National Center for Health Statistics is very interested in this, so some of the outcome will be recommendations for them, and for coding, and for classifying deaths or for documenting circumstances of death on the death certificate, and we'll also have some recommendations for the National Center for the Review and Prevention of Child Deaths on their data.

What I've done is review the circumstances of the death. I have an operational definition with three categories of child maltreatment; we have presumptive, we have probable and possible. I have a table at the end that we can talk about during the discussion with my operational definition, as well as the conceptual definitions of those different categories so you can get a sense of how that works if a death is a drowning death of a 5-year-old, where that fits. I have classified the deaths and we are going to calculate a national estimate, based on this information from these nine states, we will apply the proportions to the national and we'll have a national estimate, and then recommendations for policy and practice based on this project.

I am also, along with a number of people here, the Casey Family Programs under the leadership of Commissioner Sanders and others at the Casey Family Programs has, over the last two years, organized meetings of a measurement work group for child maltreatment fatalities. And it's a group of people, Drs. Wirth and Palusci and Commissioner Covington and I, along with Dr. Slep, we've all been meeting and working on these recommendations. I have the draft of the recommendations, we haven't gotten back together to approve them, so I just have the drafts at the end of my slides, and I'll go through them really quickly because what I would like is a request from you to me to get them approved so we can go back and get whatever we are going to approve and send them to you officially. So that is another project.

So conclusions: I believe that a public health approach is not only possible, it is absolutely necessary if the goal is to eliminate child abuse and neglect fatalities, and I would challenge you to adopt a public health approach in your recommendations. I understand how hard this is. I have been working on this for 15 years. It requires a huge paradigm shift, but I think it is critical if we want to move forward and eliminate these deaths.

In terms of definitions, a good definition is one that can be operationalized consistently over time and across disciplines. That is kind of an academic, no-brainer there. It is possible to develop a public health-focused definition of child abuse and neglect that focuses on behavior of the caregiver and needs of the child, and it is possible to do this and have people agree that the circumstances of a death meet the definition, and this definition does not have to meet every agency's criteria for child maltreatment, in fact it won't. It is, I think, not possible to do that.

And I wanted to just mention that Dr. Hunter, this morning, brought up an example of a severe malnutrition, a skeletal child, but they couldn't prosecute because they weren't sure if the mother knew. Well, if we look at the circumstances of that death and the death certificate, in my work right now at the National Center for Health Statistics, if the death certificate says "severe malnutrition," you know, "not fed by parent," we call that a maltreatment death. That is a definition of maltreatment death, whether the mother knew what she was doing or not. We're not trying to punish the mother or educate the mother, what we are trying to do is document these deaths that are related to maltreatment that shouldn't happen, right? So to prevent this from happening in the future we need to know how many happened and then you figure out how you can develop strategies to prevent those.

My work in neglect and conclusions related to that: Whatever you want to call it, I think neglect, in my belief and a lot of people I have worked with over the years have heard me say this time and again, using that word is a barrier to classifying these deaths because people think, "Well of course you had to lock your kids in the closet and starve them to death, intentionally and over time many times for it to be neglect." So I say, "What do you want to call it, negligence?" It is this continuum and it was mentioned this morning, "It's a gray area." We need to be able to classify within those gray areas. It is the elephant in the room with respect to counting maltreatment deaths right now. We need to be able to do this. I believe it can be addressed with good definitions that include several categories to accommodate this level of uncertainty in these gray areas.

It is my opinion that fatal child abuse and neglect will always be undercounted if it focuses solely on NCANDS to provide a national estimate. In order to eliminate these deaths, we need a system that not only provides consistent estimates of the burden of the problem but we have to have information on the circumstances of those deaths. NCANDS is not set up to do this at this time. NCANDS serves an incredibly important

purpose, and the majority of the records and reports to NCANDS are nonfatal. There is 800,000, 1 million nonfatal reports of child abuse and neglect a year that go to NCANDS. That is a huge amount and they do, I think, a good job at compiling those. I think that is excellent. There are very few, even if there is double, even if there is 3,000, even if it's 5,000 child abuse and neglect fatalities a year, it is a very small proportion. You all heard, during your first Commission meeting, that it would take an act of Congress to make fatal reporting to NCANDS mandatory. I believe that even if the system is improved, only deaths reported by child welfare will be included, so we are still going to miss those deaths that have no child welfare report, if you focus on NCANDS.

There is a Child Death Review Case Reporting System that I've been working with, it is already collecting these data, detailed data, on circumstances of death that are critical for classifying child maltreatment. I have been using those data for the last year to do it. I have used it in other special projects on certain kinds of death. I have used it in the state of Missouri, who doesn't contribute to the National Reporting System but had similar data for the last 20 years. And based on my current work with this system, I am confident that it could easily be modified to incorporate a decision-ruled technique that you just heard about for documenting child abuse and neglect-related deaths. All the information is there, it just needs to be tweaked a little bit to do that.

Again, my recommendation then, and these are my personal recommendations to you. I recommend that you support a public health approach to defining and measuring fatal child abuse and neglect, and this approach, because it provides those important tools that are necessary for eliminating the deaths and successfully documenting the success over time; you can see they are going down. And specifically support the development, testing, and implementation of public health-focused operational definitions of child abuse and neglect that should not rely on an agency-specific determination of maltreatment. Those would be included, obviously. If CPS substantiates it, it's in for sure. If the person was prosecuted and sentenced, they are in for sure. But it is not required that those things happen for the death to be included in this classification. The definitions should be as unambiguous as possible, clearly list inclusion and exclusion criteria, and I think this goes with the decision rule; that's what you do with your decisions. And include levels of uncertainty so that you have presumptive, probable, and possible maltreatment, so you can include those gray area ones where people are concerned about the child at risk, this risky family, but they aren't ready to say, "Yes, this was neglect for sure."

I would recommend that you strengthen the role and capacity of child death review programs to identify and classify fatal child maltreatment—that is, funding new technical assistance. The responsibility for maintaining the monitoring and data system for fatal child abuse and neglect should not be under the auspice of a federal

agency, but should be supported by federal funding, so not agencies, particularly one responsible for investigating child abuse and neglect.

So I'm just going to run through these because… I know I'm out of time. So I'm not going to run through these, but please ask me for a final version of these Casey Family Programs measurements. I know Steve is going to talk about a few of them in his own words, and then we will send them to you. There they are. So my title, my talk is, "How hard can it be?" and I always say, "If it were easy, someone would have done it by now." But I have one thing I have to show you. This is my favorite picture; it is two of my favorite people doing one of my favorite activities. And this is the end of the talk, but for me I see this as a beginning because it is the morning sunrise coming up, and I see it as a new beginning for measuring, for finding and measuring child maltreatment, and I would challenge you to please be bold, provocative, and innovative in the recommendations for doing this.

Thank you for having me.

Steve Wirtz: [05:27:40] Thank you, I really appreciate being here. I am going to try to provide you with some practical suggestions as well as what the federal government can do in partnership with states and territories to improve our ability to count and prevent these. I just want to say that I think this is almost out of order for me because a lot of what we have done in California was to help set the stage for what we've heard today, with Amy's incredible efforts to get us a standardized definition here and yet one that can actually work. I always kid her that the difference between our effort in California and hers was just, I think, was just what, a million dollars [*laughing*]. We got to the field testing and we couldn't go forward. Anyway, that's not the only difference, by all means. I want to begin and end with a statement, I think, that Commissioner Petit had highlighted, that I also come with the broader public health perspective and we bring with that a social determinants model that looks toward the fundamental causes of our problems around child maltreatment, and certainly child maltreatment deaths, that is grounded in fundamental causes of access to resources and those resources are money, power, education, social networks, and influence and so on. I think I'm going to end on that as well.

As we talked about before, it remains true that the most important number we are going to hear today is a child's ZIP code, because that is more predictive of what is going to happen in their lifetime than any other number we can provide. So one of the things I would like to encourage this Commission to do is to see their agenda to eliminate child abuse and neglect fatalities as sort of our minimum standard of care. What we really want to be doing from a public health view and from a shared values point of view is to be promoting child welfare and to be pushing the social norm that prioritizes the well-being and development of all children. So I just want to make sure the context is that.

I am an applied scientist, among many other names that I have been called. And one of the things I want to stress today is that I ran our Sacramento County Child Death Review team for years and years. I've been a clinician and I'm a researcher, and so I think I have my foot in more than two places. And what I'm going to try to suggest to you is that I have been one of Amy's strongest supporters of moving this. I think many of us on our panel were not even aware that the Air Force was moving forward on this systematic effort for many years. But that is something I think we can do, and I'm supporting that totally, and in the meantime I'm going to show you a little bit about what we did in California that I think is potentially some intermediate steps that we can take right now. So I'm going to go through many of these slides very quickly or skip them because most of it is background and has been covered.

So numbers, I'm going to give you a little bit on that. I'm going to just highlight a couple of things on these pieces here. In California, one of the things I want to stress is that deaths are obviously the tip of the iceberg, and that we can't address child maltreatment in the United States without looking beyond deaths, and that includes other injuries, it includes reports, it includes unreported cases and it includes those children and neighborhoods that are doing well. So I think we have to just keep in mind that our recommendations can't be driven totally by the deaths but rather by the broader picture as well.

The other thing I think we have heard multiple times today is that data that we have at the federal level starts at the local level and it starts even more local than that. A child dies, a tragic incident occurs, and we have witnesses or no witnesses, we have mandated reporters, we have first responders, investigators, and all of them are the ones that provide the basic data that is used for all of our other discussions. Nothing goes anywhere without that first step of someone knowing some of this data. The investigations are where the quality of the data starts and one of the things I think Amy mentioned, and I hope that you understood the full impact of that, is one of the problems in your field testing was that the system wasn't working as well as it should because there wasn't enough information coming, and that's why they changed their structure of gathering information, and I think that is critical about our investigations, improving those. Then those reporting systems, as they report they get decreasing details in large extent from going from local, to state and national. So at the national level we may have a different level of detail, and we may actually, I would say from a surveillance point of view of public health, we may not need that for those agencies that need that for policy decisions, but certainly for prevention and for others we may.

Other sources of data, I'm not going to talk about.

As you all know, and I stressed this from the beginning, that the notion of child maltreatment is a social construction. We humans create it, and it is a dynamic, and it changes over time and over place, as we've heard. And it really represents a

negotiated settlement between society's diverse cultural and social values and our knowledge base of what harms children, and so on. It is therefore reflected in multiple agencies, in multiple kinds of mandates and legal descriptions. So that is the basis of our differences, in part.

I'm going to go through these very quickly just to give you a sense. There are different ways to approach the definition. One is saying the standard of care is if it's harmful, it counts. Another is, though, corporal punishment in the United States is unfortunately still accepted as an appropriate parenting strategy for young kids. So therefore, if you went by harm or by standard that wouldn't fit, so that is another model. Howard Dubowitz has been pushing, along with many others, including the United Nations Rights of Children, a basic needs kind of model that all children need certain basic needs to fully develop to their full potential. Those are just some of the different standards.

We talked about the continuum of neglect. It really, in the end, is a balance of assessments of risk and social acceptability. Those can be resolved. I mean look at the dynamics of infant safety seats. At one point that was not even an issue, and now it is considered neglectful if an infant is not in a safety seat.

We now have these legal frameworks, and the reason I wanted to highlight this is that there are different purposes for counting child maltreatment, as we well know. One of those has to do with our legal and civil systems. The state uses power to coerce interventions and spend resources if they define a child at risk and call it child maltreatment. That is why we do this. That is why it is important that we protect the best interest of children.

However, in the United States, we also have a strong interest in parental rights to family privacy and autonomy. Call it the "family bubble" or whatever—"stay out of my house." And the legal principle behind the values in the United States happen to be minimal intrusion, and so we have to have demonstrable harm or endangerment. Those are the bases for the legal system that we now have. We need answers for those, as well as the public health ones. So I am trying to suggest some ways to approach some practical next steps. Obviously, each state has its own way of doing it.

I have talked about this many times, just to give you a sense of the different standards by which different professions make their decisions. At the top of this shows district attorneys and law enforcement, and they have a reasonable doubt, beyond a reasonable doubt standard for making a decision. So obviously they are going to have less cases than child welfare, which uses a preponderance of evidence. Different standards, and it is going to get you a wider reach. When you get to medicine, public health, child advocacy, and others, you are going to have even a wider standard, both the medical certainty and professional certainty. So it depends on the standard and depends on the question you are trying to ask.

Quickly on the California kind of thing, we obviously had the same kind of problems others had. We came up with our FCANS program was mandated to combine data sets to try to better understand this. We do other things but I'm just going to briefly summarize. The reconciliation audit approach we used to just demonstrate some value of linking data and using those linked data to demonstrate how collaboration can work better. We took five data sources, and we don't call it the "gold standard" by any means, but an "alloy standard," meaning it might be the best we can get for right now, and if it improves our system then it is of value if we aren't getting the resources or if we are not going to transition into other forms right away. So we prepared the data sets, we asked the team, in essence, "Is it a case or not?" and we followed up, we did quality control on that, and I'm not going to go through those details. But for the two years right before we lost our general funds money we did this analysis for a two-year period and we looked at these five sources. If you look at this, FCANS, which is our child death review team reporting system that reports to Commissioner Covington and the teams' national system had 273 cases, and you can see child welfare had 212, and that supplemental homicide report is what the Uniform Crime Reports piece has. So you can see the different numbers that we have there. When we then went back to the teams and asked them, "Which of these would you count?" we had 318 counted as confirmed, but as you see, we had 20 more of those cases they said, "No, we should have counted that as well," so 338 cases.

Now this is the thing I think is going to be what you have seen before. So there is our total, 336 cases in the two-year period. The Department of Justice Child Abuse Central Index had 76 of those. Our Vital Statistics had 134. The Supplemental Homicide Report from Department of Justice, which doesn't even talk to CACI, had 136. The child welfare system had 153, and our FCANS had 191, and there were 20 others that we found in doing the further review. So there is the issue. Those are not the same case. Those add up to 338 cases, and they divide like this about equally across the years, and you can look at that later for the numbers.

But one of the things we found is, if a case was in three or more of these databases it was nearly a certainty that it was a case, which is pretty obvious. If it was in two or more, it was very highly likely it was. So we used those, what we called those are as a "positive predictive value" to figure out what would happen to the cases they didn't review. There were 66 of those, and we determined that if it was in two cases then we looked at how many other cases had that same pattern and we used that to do a prediction. Out of that we ended up with the following totals: we had 379 cases for the two years, 190 average. And I just want to point out, this is a fairly extensive way of looking at the existing data, and it got us to a rate of 1.9 per 100,000, and as you probably all know, the national rate from the whole mixed systems is 2.2 or so. So California, after doing this intensive work, is still way below the national average, either because California is such a wonderful place to be and we have great parenting throughout, or else there is differences in the way that these are going about.

So with that, then, the summary of that is that undercounts exist. Single sources of data only capture 25 percent to 50 percent of the cases, and the more sources you use, the more accurate you are. Child death review teams play a critical role in this because they bring those three or more groups that need to be there together, and we need a more comprehensive way to make child death review teams work well.

So one of the outcomes of that, in part, and we're not taking full credit for that kind of thing, the California State Legislature passed Senate Bill 39, it became law in 2007, and it now requires child welfare to report as child maltreatment cases any case that was determined by CPS, or law enforcement, or the medical examiner, and you remember you just saw those slides that show that those numbers do not overlap. Right? So additionally to report annually and to include near fatalities. So what happened in the most recent report that's out, the newest one is coming out very shortly, but of the 128 cases that they had to report on that are essentially clear-cut cases, if you add up all the child welfare ones, they had 60 percent of those cases. Law enforcement had about 40 percent, and medical examiners had about 30 percent of these. So you look at that and you see why only 13, 10 percent of those, were in all three agencies. So you see why changing the law, having child welfare use at least those other two sources, increases your likelihood of capturing some of the real cases substantially. We would argue that you would also have medical doctors who are trained, board-certified count as well in the medical field, and also child death review teams when they have argue the data to do this. So obviously I am saying the critical role for child death review teams. And I do want to just talk about this framework for creating consistent definitions, we the same kind of thing, that you break it into pieces. Was there an agent that was a parent or a caregiver? Was there an action that met a standard for being child abuse or neglect? Was it causally linked to the event? Was there a child? There are issues around stillborns and abandoned babies. So age is not as simple as it might seem. There is developmental age as well, and then of course in deaths they are all severe. Essentially, we also tried to develop this standard for how the child abuse and neglect behavior could be judged. It is this risk assessment, social assessment, and there is a judgment there, and I think Amy has shown how we can standardize that judgment into a fairly standard way.

What I want to point out here is how I think the public health view fits into this. Step one is if the death was considered a child abuse death because of the agency determination, then it is in, but if it was also a child death review team determination based on standards, it is also in. Then you have noncases of child maltreatment that would go into this count. But the next question you ask is was it a third-party homicide? And that still is important. And finally, you would ask, is it preventable? And that is the broader public health question as well, and then recommendations for what you can do about that.

I think I will end. I would argue that there is also standards and procedures that can help translate data into meaningful recommendations that you can take action on, and we have done some work to develop those as well.

There are many prevention strategies that are now shown. I want to just mention, again, ending with this broader context of the social determinants of health, CDC now has the Essentials for Childhood as one of the models for how they are promoting a broader public health perspective of safe, stable, nurturing relationships and environments that takes us beyond just the elimination of these deaths, but rather the promotion of that and beyond the family into the communities and the broader context.

We have the evidence around what we need to do, we know the horrible impact of adverse childhood experiences and how they play out over the life course, and have inordinate, negative consequences across the lifespan. The World Health Organization has this kind of a model and social determinants, and I hope this body seriously considers looking at this kind of a broader model to look at our recommendations for how we can make lasting and deep change in the country.

I just want to thank you all for your time and for your incredible effort and commitment to this issue. Thank you so much.

Berger: [05:46:07] Well, last but not least we'll have Dr. Palusci.

Dr. Vincent Palusci: [05:46:21] I'm here today to discuss child abuse deaths, and I have to tell you as a pediatrician, even as a child abuse pediatrician, this is not something that we see. In my research and the work that I do, I work primarily now with Bellevue Hospital in New York City where we see all sorts of abuse, fatal and otherwise. In New York City urban, immigrant populations, children of horrendous situations coming to our country for help. We have large numbers of kids, but we still have trouble responding to them, and that is what we are here about today.

I didn't actually ask these professors what they were talking on, but you can see independently we have come up with very similar themes in our talks. As a pediatrician, I also have some public health training. It is clear to me that a public health approach is best. I think that framework, coupled to the neglect being fundamentally different, really is a framework to looking at this problem from a pediatric point of view. Today I wanted to give you some idea about how to operationalize getting pediatricians and other physicians more involved in this process than we currently are.

Now when we are working in the hospital, most of the kids that we see who come in who are alive come in with abusive head injuries, or whatever term you want to use today. Clearly we have battered children and we have kids with serious burns. We have a variety of physical injuries. They make it into our inpatient units, they make it

into our Emergency Departments. We have responded to that using safe sleep, we respond to that with Don't Shake the Baby Programs, 18 states require us to do things. So these things are already happening, yet you probably haven't noticed that these problems have gone away. And those are the easy ones to count. We know that we have to give to strict guidance to families about crying. We know that we have poor families that we have to work with the community to respond to in our offices and our clinics. But fortunately we have help from you and from our federal partners, for example, the Center for Disease Control, which has given us some serious definitions that we can use for a public health approach. And I, in my handout today, gave you pretty much the text of what I am saying now, but I started with the recommendations and I finished with the references, in case they are not already in your reference materials.

Commissioner Covington and I, and others at the National Center for Child Death Review and Prevention looked at five years' worth of cases that they had where they thought they had good data. We reviewed over 2,000 cases over this five-year period. It is no surprise that 50 percent of the cases had abuse as a cause or contributor, but we also had 50 percent with neglect. And failure to protect from harm and medical neglect are major factors which are very difficult, even more so than some of the physical neglect things we have heard about, to sort out within the public health system. Review teams continue to see how children are poor, and a large number of children in this particular group of child death reviews have been known to the system before they came in.

So we know that there are numerous strategies, such as home visiting and parent education. I know you are going to spend more time talking about the interventions that we can use, but they all stem from this public health approach to identification of the risk factors and what families need.

What is becoming apparent is that child death reviews really can emphasize what we need to do, and we have some evidence in the child protective system, in particular, that making changes to policies, procedures, and even at the agency level can make a difference.

Now Steve Yager was here earlier. I hope he talked about what Michigan has done. And the simple fact that we were able to review within the federally mandated, through CAPTA, Citizen Review Panel methodology, we were able to look at, within CPS, what was going on in cases strictly from the agency point of view. And if we could make 80 percent decreases in the deaths associated with certain agency policies just by changing simple things—new computer systems, a little bit of peer review, more training for workers that identify things, simple fixes that make big differences at that small level of using death review as the impetus to identify the risk factors.

But there is a big dilemma. We have heard that neglect is the problem, and it really is fundamentally different with regard to counties. There is a lot of research suggesting that the current systems don't pick this up. You've heard about this. I am sure you heard it from the CDC or the National Violent Death Reporting System. Uniform Crime Reports don't have this information in ways that we can use for intervention. To overcome this, we have to use some of the methods that have already been brought up here—data integration, child death review—and we're starting to look at additional elements in the systems that we have as a beginning. Then we can begin to identify what needs to be done.

Now this figure is another Venn diagram. Steve and I like to use Venn diagrams. This is also breaking down different data systems and what they contain. Here we have Vital Statistics, child protective services, child death review, MSP is Michigan State Police, and they give you the crime data for Michigan. And what we did is we looked over these to see where can we find neglect in these systems? So building on what he said, it turns out neglect is really a small number in these systems. And so if you seek to find neglect in the current data, it will be very hard to tease out. And there are methods, like somebody called it "capture analysis," which we used, or you can look at these cases and try to estimate the number of cases, which you can't find. It's a capture, and the capture comes not out of medical science but it comes out of, I think, environmental science, fisheries, etc. If you are looking for data and it is not there, it gives you a way to estimate what could be there. That is a first step in coming up with an estimate. It doesn't identify all the risk factors that we are talking about.

Here is what you might do if you get very intensive looking at cases. This is another type of death review called fetal and infant mortality review, and here you have got important roles for doctors, physicians, nurses, and other people within the hospital setting who can look at infants, in this particular case, obstetrical factors, and prenatal care. What leads to an infant dying at a very early age? And it turns out there is a confluence of things happening in cases that never make it to the death certificate, never make it to any determination of any agency when we have a premature infant die. You've got substance abuse, mental illness, violence, transportation issues, and transitions to new lifestyles. All those things sort of congregate at one side, and then you can see it gets us over to a large number of the prenatal deaths. That has to be teased out by people within the medical system, and physicians and people who know the ins and outs of some of these factors. But it also can be teased out with the public health system and the people involved in community health, not nursing and not obstetrical care. So this single system can tease out these factors and can then give this information to law enforcement and medical examiner systems. And when you start to look at some of your case examples about methadone exposure and drug-exposed babies, some of these factors come into play on how we should respond.

There is another area, which I haven't heard mentioned yet, where we can talk about reporting systems as identification and counting. Government can certainly make additional inroads into modeling state policies to improve how we count. For example, we know that state policies can affect reported abuse and neglect rates. This is a relatively new phenomenon where we can actually say how a state defines their policy compared to other states, and you can find that certain states have more cases reported or different cases reported and different cases substantiated. This has now scientifically been studied. We've also started to see that you can change the law and get a difference. We looked at clergy reporting. That was in the news a couple of years ago and obviously continues to be an issue. But for four states that changed their laws to require at least some reporting by clergy, there were dramatic changes in cases that were substantiated, were reported. So some evidence suggests that states changing their laws can identify more cases.

Neglect is hard, and it is also fundamentally preventable. We know that poverty is a factor, and a single system can be charged with tracking both abuse and neglect, but because of this I think I'm going to have to recommend that the single system is on top of this where you are going to have to break down neglect at certain ages as you look at response systems to look at these cases.

I have to tell you that another area that we see cases is in the hospital, but also in our community. We currently provide consultations for child protective services. This is a model in different parts of the country where CPS contracts with medical people to provide that additional information at the investigation level and also at the service level for families. And when we look at these cases, you can see that there are lots of kids with special medical needs. In just this year, we have been consulted on 40 fatalities. Now that has to be an underascertainment. There has to be fewer than there actually are, and yet we find another 1,500 medically fragile children, another 3,000 children with special medical needs consulted on. There is a whole large pool of children out there that need special medical care in the CPS system.

So when we went back to say, "What is going on with these kids?" when they are alive, it is general medical care, it is child abuse and neglect to a small degree, but also the chronic medical problems, dental problems, and developmental problems. They were all there in CPS, the question is how do we determine which ones are going to die? And that needs the additional support that we are looking at.

We try to categorize these. I have to tell you that our system is having a very difficult time in New York City. The worker turnover is in part a response to the difficulties of dealing with these fatalities. And what we see are safe sleep issues, congenital disease, acute illnesses such as asthma and diabetes; and these all dwarf, they are only 10 percent of cases that have abuse and neglect, which are direct causes or contributors to their death, and these are known to CPS. Medical neglect, substance abuse, and mental health issues are significant in our cases.

My last point now is, don't forget the doctors. Often when you are dealing with looking at these systems, yes, you have medical examiners, and yes, they are physicians, but many places don't require pediatricians, or family practitioners, or general practitioners to be involved in these reviews. And while I love Sam Gulino and all the people you have heard from today, Brian Hunter, it is a different perspective when you care for living kids in the office than someone who doesn't see them in that capacity. We are obviously involved as pediatricians when they are alive, and we have a unique role and contribution we can make, both generally in child death review, generally in the community, and specific reviews like fetal and infant mortality, or sudden infant death and that kind of thing.

We have partners in the American Academy of Pediatrics and the American Professional Society on the Abuse of Children who can work with us and are already starting to develop guidelines and educational materials for their members to look at this. For example, you should realize that the Academy is already issuing policy statements on child death review for pediatricians and child abuse prevention for pediatricians, and education, and training, and advocacy. Looking at toxic stress, some of the things we heard about earlier about how children respond, how are they resilient, and how we pediatricians can add to this and address this in our offices and clinics. We have a new section for the Academy where we are looking at including child death review as a specific section of pediatricians, like there is a section on child abuse, or a section on obesity. That section on child abuse is so important to the Academy that they are looking into making that one of their standard committees, if you will, or groups.

Now in preparation for today I also have to say I had to talk to my colleagues in New York to make sure I am not making this all up, that there is some reality check going on, and if you ever met a New Yorker they were very candorous. They had a lot of candor. And when I asked them, "Tell me about what you think about what is going on in child fatalities in New York," I highlighted some of the things involved. It comes down to some serious issues with funding to support reviews, and also the ability to share information. HIPAA is not seen as enabling legislation by the people in New York. While it may enable states to do certain things, it does not require them, and I have more lawyers than doctors in New York, and my hospital attorneys, even in the public sector, routinely use HIPAA to prevent sharing of information. It would be nice to have that explicitly dealt with so that the teams on the local level, as well as on the national level, could deal with this more explicitly. We would like you in New York to tell us what to do. We know what to do. But give us the best practices and the evidence to do it right, because we need your help and you have the expertise to draw in all these people at the table and all the people that have been before you.

To summarize, let me just say that to accurately count child abuse and neglect, we need a public health approach to identify these factors, there clearly are public health interventions that work, that are dependent upon how you identify these factors. We

need to know more about infants and children in the welfare system from a medical point of view and who are medically fragile. If you're going to start to look at near-fatal cases, you are going to need us, and you are going to need our hospitals to help you get to the kids before they die. Because we have to look across systems and take this information and get it out of the hospital and get it out of the medical examiner and get it into public health.

So some of this will involve new funding. I put these slides in new. These are the recommendations in your handout I gave you; I think new funding is going to be needed for certain things. One thing the New York doctors told me is we need funding not to pay the doctors but to pay the staff to organize the cases and to get the leg work done to do it properly. We need help with HIPAA. We need help with CAPTA and using that as a mechanism to require some of these things to happen. And I can't speak on some of the definitions that you've heard here, but I can speak from the child's perspective. No matter how you define this, the kids are still going to die. Let's do what we can to reduce the deaths and make this truly a response to the tragic events that they are in our system. So, Commissioner Sanders, Commissioners, thank you again. I think when we do our job here we can dramatically reduce these terrible outcomes and we look forward to working with you. Physicians are your friends. Your pediatrician is on your side and we look forward to working with you and the community to help save and preserve our families. Thank you.

Dr. Berger: [06:02:03] I gave them each questions prior to this, and we had several conference calls to try to get them to really focus in, and I really want to congratulate them because they really I think focused on the questions that we wanted them to answer. So, as Amy said we have moved some mountains and we were able to get access to the Air Force database. So I'm going to read you a scenario and then I'm going to go over there and actually play it out while Amy tells you how this would be working in real time. So here's the scenario. We're going to show you how this would work in the system.

The mother is feeding her newborn, and during the 20 minutes when she's feeding the baby, preparing the bottle, feeding the baby, burping the baby, she puts the 18-month-old sibling in front of the television in another room. She walks out of the room because she's feeding the baby in the other room, and the child gets up from the coach, walks out, opens the screen door, and gets into the pool and drowns. So the question is, how would the military, or the Air Force, in this system look at this case? I'm going to go over there.

Slep: [06:03:05] So, Rachel asked me to set the scene a little bit. So, the decision tree is on when the committee is considering an allegation of maltreatment. Again, this is for substantiation determination. Investigations are supposed to be complete, or at least people think they're complete when they come to the table. If it seems like there's more information that is getable that they don't have, then the case is

deferred, and the decision tree is run at the next meeting. The committee includes child welfare; it could include an outside civilian child welfare person; it includes the family advocacy representative, which is the military version of child welfare; it includes the cops; it includes someone from whoever the active duty member in this family is. Someone from their command, so this is somebody who knows the family and knows the house, and probably—given the way the military stuff occurs—has engaged with the family since this allegation happened. And then there's some other representatives: there's the Vice Wing Commander from the installation, who chairs the meeting, and there's a lawyer who's at the table, and there is the highest ranking enlisted person as one of the committee members. So most of those people have no background in child abuse and neglect. Right?

Okay, so before they come to the meeting, they have had to have done the one-hour-long online training that exposes them to the system and the definitions, and they have had to pass the certification quiz. And if they don't they can't vote. So, they are sitting at the table and the family advocacy person would read the allegation that came in and then the chair would ask for the [decision] tree to be run. So there is just some basic information that gets put in. There is an incident number and some demographics, and then there's a classification as to what kind of maltreatment is being considered. The Air Force uses a victim-based system, so if there are four children in the family of different ages, each of those is considered separately. Okay, so in this scenario the allegation is one of neglect, so Rachel clicks neglect and then there are categories of neglect that need to get considered. And so there is lack of supervision, exposure to physical hazard, educational neglect, medical neglect, deprivation of necessities, and abandonment. Those are all defined, but in this case, I think it's probably pretty clear that this would be considered under lack of supervision.

Petit: [06:05:53] Can it be two at a time?

Slep: [06:05:54] It can be two at a time.

Petit: [06:05:56] So it's obviously exposure to physical hazard.

Slep: [06:05:57] Right, it can also be exposure to physical hazard. Those would run about the same way in this scenario. So they'd probably only pick one. Okay, so at this point then the first criterion comes up, this is in the conceptual map of the definition, this is for the act of omission. Okay? So this is for lack of supervision, this is an egregious absence or inattention by the child's caregiver. Child's age and level of functioning should be considered in making the determination about the level of supervision required, and there are some little notes that are military-specific: leaving children 10 or older unattended in a vehicle, the Air Force has a rule, you're not allowed to leave a child under 10 alone, ever. But leaving a nine-and-a-half-year-old alone for five minutes is probably not neglect. So we needed to have extra things in

there to help people remember the difference between the base rules and making a neglect decision.

So, what would happen is the chair would say, "Okay, so let's consider whether it's an act of omission here," and Rachel read the scenario. So the question is, is this an egregious absence or inattention by the child's caregiver? So, what you would want to know and then *egregious* is bold because there's the definition of egregious. So if you click on it with your mouse it should work. There you go. Oh, good. So, this means that there's a striking disregard for the child's well-being. This is not merely an example of inadvisable or decision parenting, but this clearly falls below normal balance and normal parenting, which doesn't explain it a whole lot. What we're trying to do here is give people room for there to be a different standard for a typically developing child or a child with Attention Deficit Disorder. For a child who has slightly different medical needs than a different child. For a child who is very, very calm and controlled versus one that's really impulsive. Those are all real. And if you make the definitions be very rigid around things that are easy to observe, it seems like in the field trials we lost more than we gained. But we could get people to think about this as their threshold.

So at this point there would be a conversation, and my expectation is that the conversation would be things like, "Well, what do we know about this kid? Does this kid wander out of the house? Do they usually sit?" And somebody would say something because somebody would know the kid and would say, "Well he's pretty typical, looks like a pretty typical toddler to me. When we were in the house he was wandering around and playing with stuff. He doesn't sit for a half hour and watch television by himself." Of course not, no toddler would do that. They'd ask some questions about the mom. There would probably be a little conversation about the pool. How easy or difficult it is to get out of the door. Whether the child has ever opened the door before would probably be a conversation that would be had, and so if this scenario was, "Well, yes, the mom knows that the child can open the door." And this is a typical 18-month-old that doesn't necessarily sit in the middle of the day and watch television for a long period of time without moving. Then they would then call a vote and the committee would vote. They'd raise their hand about whether this was an egregious act of omission. And if it was the things most people would probably say that there was. There might be one or two people who said they didn't. Their votes would be recorded, and it would get clicked, and you'd move to the next screen. So in this case the first kind of impact, for substantiation, there are 100,000 possible impacts for neglect. I think there are seven, but it feels like a lot.

So the first is, "the child had a more than inconsequential physical injury." And in this case, the child died. So I think that's pretty consequential. So you would close that and everyone would vote yes, because it's sort of unarguable. And that gets us to where Patty was saying the way it worked with these meetings is that before there was a decision tree, people would fight about whether he was a good guy or not a

good guy, whether she's a nice parent or not a nice parent, whether she's in the PTA. All sorts of things like that. Once there were criteria, people would say, "Oh, well, according to that, yes." And it just made it so much simpler. And even the people who didn't think there was an egregious act or omission would agree that there was an impact, and you need just an act and an impact and that's it. You're done. And the decision would pop up. So I think Rachel has some more scenarios, and she's coming back.

Chairman Sanders: [06:11:04] Actually I think we're probably going to want to ask some questions first. I think there are probably a number of questions. Commissioner Petit?

Petit: [06:11:14] This is all extremely interesting. I have three questions that pertain to national policy that gets derived from this thing. One is in almost all indicators of child well-being, it's a rate per 1,000. When it comes to child deaths, it's one per 100,000, which speaks to how few of these there are in absolute relative terms but how many there are in absolute terms. Do you understand? The question I have is when you get into the predictive aspects of this, is it around the aggregate data that is per 100,000 children there are maybe 1,000 that look like whatever the values are that you're saying are not positive ones. And even at that number, there are only two kids that are dying. So when you talk about predictive, how much is it based on aggregate data, or can you bring it down to an individual case situation?

Wirtz: [06:12:12] Let me start, because I had thought of one thing that you had already heard from Dr. Putnam-Hornstein. I think you're going to hear more from her. California has one of the best data systems around for linking birth and death data with the CPS records, so she's been able to put together a half a million cases for this predictive kind of thing. One of the things that she found that we haven't fully implemented into policy is that she has found that five variables on the death certificate are very predictive of involvement in the first five years into the child welfare system. And so it's something on the order of, to give you a sense of, no it's not individual it is still predictive and it gives you focus of where you target your effort, but 15 percent of these cases had these five predictive values, and they produced over half of all of the CPS reports and substantiations within the first five years of life. That's very valuable information, and those are large numbers. So we still need a system that provides services to a much larger number than the person who would have died, obviously. But nonetheless, predictive efforts like that can be very powerful in helping use money as effectively as possible, if we do all those other things along with it. That's one answer.

Petit: [06:13:43] The second question is for Professor Schnitzer. You and I have talked before about what the actual number is of children who are killed, and when we wrote a report on this a few years ago we used the number of 2,500, and that was based on the fact that the federal governments number was around 1,700 and we said

let's just take half of that and we'll call it roughly 2,500. You and I have talked about this, and you are an expert on this underascertainment question. I wonder if you or anyone else in the panel can say what you think is the actual number? I know it's not going to be precise, but one of the things we are being asked to do is to report back just what the dimensions of this problem are. You've done a number of studies on this. What do you think the number should be?

Schnitzer: [06:14:24] It depends on how you define it and your purpose. I've gone out on a limb saying how I think you should define it, and what I think the purpose should be. So in my research using a public health approach with a pretty broad definition, so even though I have categories, I have different levels of classification, it's a fairly inclusive definition for young children. So all my work has been in children less than age 5, and those are the children at highest risk. So what do I think the number is? Well, in Missouri an original work I did in Missouri eight years of child fatality review data when we had information on supervision. So we had injury deaths of these young children with no supervision information. We didn't include those. But when we had information on the supervision at the time of the injury, I think it was 75 or 80 percent of the kids were not supervised at the time that they had an injury severe enough to die. Okay? I can't remember—it's been a long time since I've looked at those data. There's a number of children where we didn't have the supervision information, but earlier, in the earlier panel, I think it was Dr. Mohr who talked about supervision in the pediatric emergency room, and I've done research I didn't even talk about today on supervision and injury because that is a huge indicator of injury deaths of these young kids. So I'm afraid to give you a number. I think it's more than 2,500. I would say based on the current work I'm doing in these nine states and I have very, very preliminary numbers I don't have a number, and it's only nine states, but I can give you a proportion. So … older than 8 days, less than 5 years old in my categories of presumptive and probable, which I could show you what that includes, it's about 12 percent of the deaths of kids, of all the kids who died, would have been classified as a maltreatment presumptive or probable maltreatment death, based upon my classification. That's two-year data in nine states.

Petit: [06:17:06] What is that as a number?

Schnitzer: [06:17:12] Well it's not a national number, it's only nine states, I haven't done that work yet to estimate the national number. But in a couple of months I'll be able to have that for you.

Petit: [06:17:23] One of the things that we are charged with is making recommendations on stopping child abuse deaths now. Not downstream but right now. In the public health model that we are all addressing, which I think everyone on this table would agree that we need a stronger public health intervention, but in the "right now" situation where there are children in every single state that are in harm's way with the families that they are with right now, a public health model, what would be

the applicability of what it is you're talking about with respect to a kid living in a household with a former prisoner that sub-abuses, mental health issues, child hasn't been removed yet, public agencies know what's going on … is there in that narrow set of circumstances applicability using a public health model for that population? Not long term, just right now. We have a case, I'm calling you up, "What have you got that I can use to help this kid?"

Schnitzer: [06:18:019] Absolutely. I mean that's what the public health model is all about. We know what puts young children at risk. We know those family factors. It's what Steve was talking about—the social determinants—but it's all the same whether you call it maltreatment or just kid's injury deaths in young children. Whether they are maltreatment related or not, the social and demographic factors are all the same. We know. We can identify families at risk. Whether that individual child in that family is going to die, is at risk of dying a maltreatment death, we don't know. That's an individual-level assessment. But in terms of the public health model, we know. So what I've said in the past is use that information to focus the few resources that you have. Right? So if you have a family that's reported to child welfare for neglect, the problem with child welfare is they are overwhelmed with horrible situations. So if someone just gets a report for where the neighbor sees this kid out in the front yard and we think it's not adequately supervised it's very difficult to do, but that's how you would do it is to say, okay, we know kids are at risk, young kids when they aren't supervised. We know this is a high-risk family based on the ZIP code, what can we do to offer these services? And what I've always been a proponent of, because child welfare can't do it alone, is to partner with public health. Home visiting is often a public health program. So if you can identify, if child welfare identifies this high-risk family but they can't, either it's not a substantiation issue or they investigate and it's "well we can't," the services provided … child welfare doesn't necessarily have to have those services. The community as a whole should be able to support that family in need of services to help prevent something bad from happening to that child.

If it's daycare, look at your daycare policies. We know that young children in the care of unrelated adults, especially unrelated male adults—and often you see a poor working mom working her butt off for her young kids with no daycare assistance—but if we had better policies and community support for daycare for single or unmarried women or unmarried men who don't have daycare facilities, then that's going to reduce the risk to those individual children, for either neglect or abuse deaths. They are high-risk for both.

Palusci: [06:20:55] One additional part of the public health perspective is literally that part of looking beyond the individual care and the services to the political policy world that says that we need those home visitations. We need that targeting program. We've changed the values within the social community about the value of children. And that's part of the public health perspective is trying to promote a value that all children need safe, secure, nurturing relationships and environments in order to reach

their full potential. That's part of the message that we have to share with the public and have them realize that their kids, as well as all kids, benefit when we all share that responsibility.

Chairman Sanders: [06:21:40] Commissioner Martin.

Martin: [06:21:43] So I'd to thank the entire panel for the work that you've done and presented to us. I have a couple of questions about the decision tree. So I'm a judge, so you'll know from where I come. If I understand correctly, the training that the participants receive could be done the same day that they start doing the work. Is the training designed or focused on how to use or how the decision tree works, or is the training focused on what is abuse?

Slep: [06:22:22] The training is a little bit on the process so they understand what the process would look like and what their role is, and mostly on what is abuse. What are these operationalizations that are being used here, and how should you be applying them to scenarios that you may encounter.

Martin: [06:22:44] So I have two questions based on that. The first one is, I have some itch about the reliability of it and I know that you've explained it, but can you give it to me in a one-liner again.

Slep: [06:22:58] In the last field trial and the dissemination trial, which are the last two times that we evaluated the reliability, we had folks from my research lab and from Air Force Family Advocacy Headquarters, who are very much experts in maltreatment, listen in to the committee's meeting and we made our own determination. And we recorded the determination, all the votes that the committee members made, and we matched those up to see if we all agreed, and more than 90 percent of the time we agreed.

Martin: [06:23:37] Okay, and is there an anticipation that this decision tree will be backed up in the system, so making determinations about at-risk families for preventive measures, for instance.

Slep: [06:23:53] This tree is only made for the process of substantiation.

Martin: [06:23:57] The idea, the concept of the decision tree.

Slep: [06:24:01] So could one back it up? Absolutely.

Martin: [06:24:04] Thank you.

Chairman Sanders: [06:24:08] Commissioner Dreyfus.

Dreyfus: [06:24:09] Thank you very much. So I'm going to need to be educated here a little bit by you all. So I worry in public policy about pendulum shifts. We get a great idea and swoosh, here we go. I really appreciate the public health approach. I think

the welfare of our children is a public health issue, and the maltreatment of children absolutely a public health issue. When I hear "public health approach" I begin to get a little bit... about whether it's a public health approach, a public health interface, and let me tell you what I was worrying about as you were talking. I was worrying about the children that I have actually held the hands of in intensive care units, were dying from intensive head traumas in systems that I have operated, and crimes have been committed against these children, and people need to be held accountable for what has happened. So I worry a little bit about a pendulum shift, because at some point people also have to be accountable for their actions that caused the death of a child.

Schnitzer: [06:25:10] Absolutely. It's not in opposition to that. So I think that all the recommendations you heard this morning. All the actions they are doing here in Michigan and other recommendations you've heard about improving, especially the first panel, improving the child welfare systems, improving law enforcement, improving information at the prosecutor's office, all those recommendations that would help those individual agencies, organizations, or professions do a better job at documenting child maltreatment are critical. They all complement, that would allow those individual entities with their required definitions and their required legal and social determinations to function better and more completely. So it's not in opposition at all. Absolutely those things should be done and complement … a public health approach would also clarify some of the issues that you've heard are complicated, particularly around neglect. And what is neglect or what isn't, or how do we count this? How do we include the grayness.

Dreyfus: [06:26:37] Yes, the neglect, I absolutely get it.

Schnitzer: [06:26:40] So I am glad you asked the question because in no way would I want to infer that people shouldn't be held accountable when they do horrible things to children. Absolutely they should. And people who inadvertently do horrible things to children should be held accountable. But also we should be able to protect other children at risk when something really horrible or really, "Oh my God, the mom just..." we should be able to work on strategies to protect those children also. The objective piece of the public health definition approach is that you don't sit down with five people and negotiate whether, "well really she didn't know," or "this has never happened before so we really don't want to count this, she's really a good mom." So to take out some of that subjective, because we all feel bad and I think it was Dr. Mohr I think this morning, even with her own kids she's had this point of, "Oh my God, something could have happened. I took my eyes away for longer. I was downstairs longer than I wanted to be …" She didn't say this, but every parent has had that, and that is one of the things when we did our research in child death review that makes it so hard to say, "yes, this is neglect." Because you have this personal feeling like, "Well I would never want to harm my child and I know I've done that, so this couldn't be neglect when this happened."

Wirtz: [06:28:23] I would argue that the child death review team does not represent this paradigm shift of moving to public health. I'm in public health, but I know other fields do just as well as we do in looking at comprehensive things. So I would frame this slightly different. Both in terms of the child death review team as being able to make a determination about accountability and about those cases that either go to the prosecutor or go to law enforcement or go to CPS. So to me, I think that's where we could have some clearer intermediate steps. As you've heard, I'm a very strong public health advocate as well. But I've been in the field enough to know that I also what to have a way to focus on those cases that need to be taken to these other components here.

Dreyfus: [06:29:12] Thank you. That really helps with the death review. Thank you.

Chairman Sanders: [06:29:16] Commissioner Bevan.

Bevan [06:29:20] I'm having two problems; I'm hoping you can help. What's hurting me is that one, is that we've learned from Emily Hornstein, in her testimony, that the best way to predict abuse is to look at the past behavior and that you can identify like 50 percent of abuse or deaths from looking at the past behavior. She also said that it's possible to basically roughly identify 50 percent of kids when they're born who will be reported for abuse five years down the road. I've got those two things in my mind. She talked also about moving upstream. Strategically, how we can go and use this for prevention. CAPTA as you know requires that we develop a safe plan when kids are born. Yet, the CAPTA safe plan is limited to, it mentions substance abuse, so it wouldn't capture the variables that Emily listed. You know: unmarried, young, child, newborn, that kind of stuff, those five factors. What can we do? Should we do more in CAPTA in terms of newborns? And can we identify about 50 percent? In terms of being bold, I want to be bold, and I know we might risk targeting people. Some people would say, "You're targeting." Tell me if it's worth it.

Slep: [06:31:13] Well, I think that's where the public health approach is, in terms of response, is particularly appropriate. You wouldn't want to—because somebody has five risk factors—have a child welfare worker on their doorstep every Monday morning to see how they're doing.

Bevan: [06:31:30] No, but that's not what the safe plan calls for in CAPTA.

Slep: [06:31:33] But there are a lot of, there are at this point a lot of light-touch preventive skills-based intervention that are evidenced that they help reduce risk from maltreatment. And it might be appropriate to say that if you're at risk you are going to get some sort of support or resources. As long as we have a way then of making sure that we can actually connect people with the ones that work. And I think that is sort of the point of a public health model, is to find folks who are at risk and give them services that help deflect them off that risk trajectory.

Palusci: [06:32:20] Could I answer that, too? From the CPS point of view, too, they may identify the risk factors that we've heard about. And they may have CAPTA supporting certain services and prevention. But do they have the expertise to really tease out what those particular leads are? When you have a mom who has substance abuse or mental illness, of course we don't want to remove the baby from that family. We want to provide a safe environment with mom. That is our goal. But even our CPS agencies in New York will tell you they identify these but the services don't keep up with the needs, either in quality or quantity, and those risk factors that you're talking about don't get addressed. And then predicting who's going to die is very problematic. Because you have a large number of kids that meet these criteria. We have 60,000 reports in New York City; only 60 kids based on current estimates will die this year that we'll know about. That's one in a thousand. But we have to give 999 other kids some of these services. Will we see the difference in deaths? I don't know.

Wirtz: [06:33:25] Another thing, just to clarify, I wouldn't say that's the best way. It is a useful tool. So I mean, one, we're not saying that's the only way or the best, I just want to clarify that. Second, I think that's where the partnership comes in. Child welfare can't do all of that, and that's where partnering with other agencies, "How's the Nurse-Family Partnership going?", "How's the public health nurse doing?", "How are our community health workers doing?", "How are AmeriCorps workers doing ?" in terms of setting up family resource centers in communities that help mothers get education and jobs and so on. That's the only way that we're going to have a systemic way of dealing with those large groups that have large, at-risk families. We can't go at it one-by-one. That's the point of a public health model and of a predictive model. It's a population-level approach.

Bevan: [06:34:17] Unless you identify, you can't help. You can't marshal those resources. I'm not saying remove the child. I'm not being punitive about it. I'm saying be positive and be able to prevent, and if we know something. We've sat through lots of hearings so far; lot of services don't work. Most services. I have not heard too many beyond … and even home visiting, even David Olds will say, "Home visiting didn't work everywhere." So, you know, we have not found the perfect service yet. Part of our charge is to identify effective and ineffective services.

Slep: [06:34:56] Well, there's never going to be one service that meets every single family's needs regardless of what they are.

Wirtz: [06:35:05] Remember we are here supportive and we have various experiences, but we are trying to look at how data and how collecting information can help in the process.

Bevan: [06:35:16] That's right. But if you're saying that Emily's data, I'm saying it's useful, but then how do we operationalize it, and the response is, "Well, we don't want to over-service too many kids because this isn't really productive."

Slep: [06:35:31] Well, I think the challenge then is to look at folks and … this isn't the expertise that the panel in front of you has, but I know a little bit about it. But there are models out there that are trying to figure out how to deliver effective services in very cost-effective ways. And having tiered models of prevention so that the whole population gets information pushed out, and then based on either self-selecting up to more intensive levels or referrals to more intensive levels you get the most expensive services, and some of those models have been found to reduce rates of child abuse and emergency room visits and CPS accounts and all of that in trials in South Carolina. So there are some of those sorts of systems out there, and that might be more a Triple P trial.

Bevan: [06:36:25] Thank you very much.

Chairman Sanders: [06:36:28] I have a couple of questions, particularly for Steve Wirtz and for Amy Slep. So, Steve, you talked about the combining of five databases and what that offered, and one was the Child Death Review Team and one was the SACWIS system in California. And I am curious whether the Air Force System, would that be applied in the child protection system as they get reports of a child fatality and do an assessment or come to a conclusion of whether it's abuse or neglect. Are you seeing that potentially as part of the child fatality review team process?

Wirtz: [06:37:20] Just to clarify, I think we were saying that one very variable place to put is obviously in the child death review team because that brings together this multidisciplinary, multiagency group that has these different perspectives about what the standard is and so on, and that would help them find a way to have consensus. So originally what we proposed is that that be a tool to be adapted and determined to see how it would work in a child death review context. So that's one level. The second is I think I'll turn to you about how you did it in the Air Force.

Slep: [06:38:00] So the Air Force was doing this, again, just to make substantiation determinations in these multidisciplinary committees. When the Air Force did their own child fatality reviews, and at that point it can come to them either as being a child that they know about from child abuse or neglect or through one of the other channels. Just exactly as it happens in a civilian world, there's a dead child. They look at that. And they do fatality reviews for all children because it's a smaller institution. Right? So they are able to do fatality reviews for all child deaths, and that way they are able to do this more comprehensive assessment to try to determine the extent to which abuse and neglect was playing a role, even if it doesn't get flagged as an abuse or neglect death.

Chairman Sanders: [06:38:52] So two questions but both related. One is do you have a sense of the cost being the Air Force to have implemented this? Just some idea, and if you don't that's fine. If you could maybe submit something in writing.

Slep: [06:39:11] Sure, I can look into that. It depends on how you think about that. Are you talking about the setting up of the infrastructure and the computer systems? Or are you wanting to include all personnel time from everyone who ever took a training?

Wirtz: [06:39:27] Or developmental cost?

Slep: [06:39:28] Right.

Chairman Sanders: [06:39:29] It seems like it has to be all of them if those aren't in place right now. A sense of what all of that would be.

Slep: [06:39:35] Okay, on the infrastructure side and the development it was probably a couple of million dollars that was spread out over 10 years. And on the training side I'd have to confer with others and submit something to you.

Chairman Sanders: [06:39:52] Thank you. And Steve if you could say just a little about what it took and what it would take in other states to combine those five databases?

Wirtz: [06:40:03] Well in other states … for example California has a very good supplemental homicide reporting system that many other states don't have. So part of that would be to test whether it's five or four or whatever that they might use. In terms of cost, it's nothing on the order of that. It's a couple of staff people to do that kind of linkage to get access to those data sources. I do think, the harder issue … in order to use child death you can dwell in that system, you have to then go back to what we've said about strengthening them, giving them the authority and the responsibility to make these determinations. And so that part of it is a bigger piece. But the epi part of it, the surveillance part is straightforward, and I would argue that it has worked extremely well in California to get a standard way to make sure that CPS is looking at other sources. I would also just point out that NCANDS allows right now, allows other sources of child maltreatment deaths to be reported. And I would urge for the short-term that that be one of the ways that NCANDS gets improved is to formalize that, maybe through CAPTA, but I think you can formalize it. They need to have included all those cases that are clearly defined as such in other domains. I think that would be a major improvement, and I think states could do that.

Now that part of their work is a CPS issue, and it involves training and all kinds of steps in that, but that is certainly a reasonable effort there. I would also say that I think there is a value now for NCANDS to be a surveillance tool for child maltreatment fatalities. I know that that's not the views of everyone, but I'm of the mind that consistent data is valuable even if it's off. Even if it has error built into it. Obviously this would have error, but I still think I'd rather have a number that was based on something we knew about that it was coming from multiple sources than to not have that while we build a better system. So I am really urging child death review teams

strengthen, and using the NCANDS program right now to better count these cases. As soon as child death review teams feel like they are up to speed and have the resources to do that, I would say that should be one of the sources that they have to accept. But until we have some of these standard definitions that it took you guys 10 years, we could probably cut that down to two now or something, but in the meantime this would be an improvement as well.

Chairman Sanders: [06:42:52] Commissioner Petit did you have one last question?

Petit: [06:42:55] Yeah, I would remind myself and the rest of us that the law that was adopted is to eliminate child abuse deaths not eliminate child abuse. And I know that in the end you can't reduce morbidity at the mortality rate without addressing morbidity issues. I mean they are very much related. On the other hand, there may also be differentiation between stopping child abuse and stopping child abuse fatalities in a way you are saying there are differences between addressing neglect and addressing physical abuse. Right? So I think again for me, the postmortem achievements that we're hearing today and elsewhere in which we know better what is causing the deaths of these children and how to classify them still need to be translated into what happens before death so there is no death in terms of actualizing that policy and making that. That's what I'm not hearing yet. It's not a deficiency here. It's the same thing that Commissioner Bevan was just saying about going around the country. We're not hearing the specific kinds of things that say, "Right now this particular child is at risk. Forget long-term intervention. Right now, this child is living in a very dangerous situation. What do we do?" I think part of that is eventually going to involve law enforcement and prosecutors in criminal courts in addition to the civil proceedings that right now largely overlay the child protective service system.

Chairman Sanders: [06:44:21] And we have one more comment and then we're going to have to take a break. Commissioner Covington?

Covington: [06:44:32] This is more of a comment to the Commission. I thank you guys a lot for all the work you've been doing, because we are charged as a Commission to try to create recommendations toward improving the measurements of these fatalities. You had asked about where can these conversations happen, and we just can't forget the fact that every state has these child death review teams that are having these deliberations. Many of them not as well trained as they should be. To me some of the recommendations here are … while we are trying to create some system definitions for these teams that are meeting with very multidisciplinary services to try to get to some determination of whether abuse or neglect occurred in these deaths can't be understated. In terms of using that resource that's out there now, and then trying to build in some type of more formalized decision-making criteria to help these teams. And remove some of their bias from all of their different perspectives that we can come up with some better definitions. I think it's just the way to go.

Slep: [06:46:36] May I just make one response to Commissioner Petit?

Chairman Sanders: [06:45:38] We are way over. I think we're going to have to take our break. Thank you very much for the time, and we look forward to hearing from you multiple times because the information you provided is very foundational to what we need to do, so thank you very much. We'll take a break for … I'll say five minutes …. and then we'll reconvene with our next panel.

Afternoon Break: [06:46:06]

Chairman Sanders: [06:55:46] All right. We are going to go ahead and get started with our last panel, which is on prevention strategies with some specific focus on, "Are they actually reducing child fatalities, and how do we know?" If those of you in the back could begin to take your seats, we are going to get started. So we're going to start with Stacie Bladen, who's Acting Deputy Director, Children's Services Administration. She'll be followed by Brenda Fink, the Director of the Division of Family and Community Health, Bureau of Family and Maternal and Child Health. Michael Foley, who's the Executive Director of the Children's Trust Fund; Kaitlin Ferrick, who's the Director of Michigan Head Start Collaboration; Blandina Rose, Project Director, Promise Neighborhoods, Black Family Development, Inc., and Stacey Tadgerson, Director of Native American Affairs, Michigan DHS. Ms. Bladen.

Stacie Bladen: [06:56:44] Good afternoon, Mr. Chairman and fellow Commissioners. Before we get started I absolutely must, even though we are short on time, recognize the Commission staff, who's been truly excellent and professional to work with in planning this event. Liz, Randy, Cheryl, Tom, Patricia, and Karen, and I know there are others but I had to get that out there. Thank you.

In this presentation I am going to describe a unique statewide systemic prevention and protection effort initiated by our Children's Protective Services unit, called Birth Match.

In a nutshell, this is an automated system that identifies newborns born to families who have had prior known significant history with Children's Protective Services. In describing the Birth Match system it is my intent to demonstrate first how two large state departments can collaborate effectively by pairing birth data and CPS data to identify children at high risk. Second, that this use of data, when combined with a thorough CPS investigation that includes the application of anticipatory abuse and neglect doctrine, is an effective approach to preventing child fatalities. The Birth Match system was precipitated by the death of one infant and severe physical abuse of another in Detroit in the same week in September 2000. The victim's names were Miracle and Jamar. At just 7 months old, Miracle was found inside a bag with a blue washcloth stuffed in her mouth. Her head was covered with white utility tape. An autopsy determined that Miracle suffered a close head injury and suffocated to death because her airway was blocked. The mother's boyfriend hid the body in a plastic

grocery bag in a field under a tire and tube log. Before Miracle was born, her mother's parental rights to several prior children were terminated by the court, and she was found unfit as a result of abuse and neglect.

At 5 months old, Jamar stopped breathing after being beaten. He was revived at Children's Hospital. Before Jamar was born, his parents had significant involvement with CPS, including termination of their parental rights to other children, due to abuse and neglect.

Michigan law already required a court petition if parental rights were terminated to another child and CPS determined that there was risk of harm to the newborn. The problem is that there was no mechanism to notify CPS of the fact that a newborn was delivered to parents with a prior termination history. Rather, it was left to chance. So when Miracle was born, even though her parents had prior terminations for abuse and neglect and there was a court determination that the parents were unfit to care for Miracle's siblings, the parents were allowed to take Miracle home. There was no notification to CPS and no opportunity to assess Miracle's safety given her parents' history. The Department of Human Services and Community Health determined that there should be a way to provide this crucial information on newborns to CPS.

So in 2000, our Birth Match system was developed. Birth Match is an automated statewide system that notifies CPS central when a child is born to parents who had prior termination of parental rights as a result of child protection proceedings, caused death as a result of abuse and neglect to a child, or perpetrated egregious acts such as severe injury or sexual abuse. A CPS complaint is assigned; a supervisor receives an email alert, it's automatic; and the local office has to verify that the match is correct before going out. This is not to say that every child born to a parent with prior terminations requires protecting intervention or court involvement or that their parental rights will be terminated. However, under Michigan law the mere fact that the prior bad act of having one's parental rights terminated in a child protection matter can be used to establish grounds to terminate on a future child. State case law will provide in Dittrick and LaFlure the doctrines of anticipatory neglect, which say: "How a parent treats one child in his care is evidence of how a parent would treat another child in his care." And further, the court may take jurisdiction based solely on the basis of a child's treatment of another child. The parent's treatment of another child and then that will provide the doctrine of anticipatory abuse, which allows the court to use the person's prior abuse of a child to show that they will likely abuse a child in the future.

The success of Birth Match depends on a strong, committed relationship between DCH and DHS, and a willingness to share data. When a match is made, a full CPS investigation occurs and includes an assessment of threatened harm. CPS doesn't simply look for evidence of current abuse and neglect but may confirm abuse and neglect based on a finding of threatened harm. And threatened harm means that harm

is likely to occur based on a current circumstance or an historical circumstance, absent evidence that past issues have been successfully resolved.

So in the case of Miracle and Jamar, CPS would have concluded in its investigation an assessment of what led to the prior terminations of parental rights and whether those conditions and circumstances still exist or were resolved by intervention or changed circumstances. In the absence of satisfactory resolution of prior harmful conditions, a CPS determination would have been made that Miracle and Jamar were likely to be harmed. CPS would have confirmed neglect based on threatened harm and filed a petition for protecting legal intervention. In many cases, parents have successfully resolved prior risk factors and court intervention is not necessary.

This is the last slide, and I just wanted to give you an idea that instead of leaving it to chance, which did not work out for Miracle and Jamar and many other children, CPS was able through the Birth Match system to protect 49 children in 2013 from likely harm, 74 children in 2012, and 82 in 2011. I will leave the Commission with the following points of emphasis: Interagency collaboration to protect children is key; infants are at the greatest risk of abuse and neglect fatality; we cannot leave their protection to chance; data must be used more strategically to identify and target at-risk newborns and their families; we have to act boldly in our investigative approach; laws and policies need to support an anticipatory harm approach, in which CPS and the courts may intervene based on significant or egregious unresolved prior acts. Thank you.

Brenda Fink: [07:03:42] Hi, I'm Brenda Fink, and I work with the Department of Community Health, and in that role I work in the Public Health Administration and I'm responsible for the majority of the maternal and child health services and represent that perspective in terms of the systems development and so on. I had no idea in preparing my remarks that we would have such a robust discussion of the public health approach just prior to doing this, so I feel very on the spot, but eager to talk about what it means to take theory into practice. I would also say I have come more recently in my career to public health. I am not born, bred, and grown-up in the public health system. I began my career in fact in Illinois, doing child welfare in the Chicago area in very high-risk neighborhoods. And followed that with doing school social work for a number of years in special education in those very same neighborhoods. I moved to Michigan and worked for many years with the very high mental illness issues represented in the community mental health system. So, I feel like I've been through in various boiling caldrons where need is most intense, where the ability to try to impact very high-need, highly risk-laden individuals has been very present, and I've worked over the years, because we've always taken a multidisciplinary approach and had respect for the public health approach as I understood it at that time, which for many years sort of consisted of, "Oh those are all the people that bring all their charts and graphs with wavy lines and spend a career telling me that alcoholic parenting

wasn't a good idea and it didn't help the child out" and so on. Needless to say, my understanding at that point in time was quite limited.

Now, I am one of them. So I think what I would like to do is approach this a little bit different than I was planning to. Some slides I'm going to move through very rapidly. What I wanted to stress and talk about is what it means on the ground to try to integrate systems. Some of the challenges, some of the things Michigan is doing, address that whole life-course perspective, and again the challenge is not only to understand the theory but what does it mean in practice? What does it mean you do? And how are you constantly weaving between the here and now and this family and this child and this infant with the design of a system that is both dealing with the now as well as the trajectory over time. That is always the challenge that is in front of us.

So Michigan's approach, as you have heard, is very committed to a cross-systems approach. There are things we are learning to do better. What we have recognized, I think, at least at some level, is that it takes all of us to get the job done. It takes a village to raise a child. Across public health systems you need all of the pieces in order to address what it is we need to do. There is a deep and shared commitment to core issues around infant mortality, to children who survive and thrive, to reducing and eliminating child fatalities. It is something in this state that all departments are committed to. So it begins with an alignment across the three major public systems, which you see on the slide. I should mention the Community Mental Health, the department encompasses in this state both the public health services, the behavioral health services—both mental health and substance abuse—as well as the state Medicaid agency. So we are constantly working with both the health care system as well as the community side of the resources.

One example of what we have done, and you have a full page of this slide, if you actually want to pay attention to what it means later. For example, we can draw a complete flow chart in our early childhood system of how information, planning and development, and so on occurs in the early childhood system from the governor down in the local communities. How we have formally, organizationally organized ourselves administratively to deal with operational issues, as well as policy issues, as well as major direction and so on. A lot of states have and Michigan has had in the past ways in which departments come together. But I will give an enormous amount of credit to Director Corrigan, Director Haveman from the Community Health, Mike Flanagan our state superintendent, to making this a meaningful organization. Many times it's still a meaningful way to do business. I am involved with the person from the department very frequently with helping to prepare issues and materials that come out of the system that we're talking about here today, the kinds of issues that impact what's done. Are they able to deal with every single issue? Of course not. But we are getting a high number of things that they are able to do.

I'm going to quickly go through a pair of, number of other slides that there are things that we work with that are essential to what we do, working with elimination of disparities and so on. You've heard a lot, I've given some examples of the way different systems come together everywhere we touch a child. Everywhere we touch a family, what we are doing to address identification of abuse and neglect, identification of the factors that impact across all three departments and through a wide variety of different kinds of activities and screenings and connected service passages, and so on. We talked a lot about the public health role already and the kinds of data and surveillance that we do. There are a number of slides with some of that data. Life course theory basically says as you know that there's a cumulative effect that adverse childhood experiences, social determinants of health, that it matters to individual health outcomes. It matters what kind of community and what kind of resources are there. It matters very much what sort of system infrastructure is in place, everything from the funding to the types of programs and interventions that are used to address that.

So as we move forward, I'm just going to skip a bunch of these. We have again the public health flowing charts of up and down. But as you begin to translate that to practice, what we do is you take every single one of those arrows and you not only understand what it means in terms of its predictive analytics but what are the best practices. What are the ways that both as a system and then in terms of aggregate, but what are the tools you use with any given individual family, individual child that will bring out those issues, those risk factors that most need addressing, and what are the best practices and resources they most need. Are those resources always universally available? Not yet. But at least it gives us a heck of a better idea in a much more focused way around how to match resources with known ability to impact outcomes and risk factors that this child or family or parent has.

Again, some of the protective factors. We talked about adverse childhood experiences, but as you get into that life course and cumulative thing you're experiencing parents whose ability to parent, whose stress level has been very much and their choice of behaviors very much then shown with what happens with the child. And so many children are more difficult to do than not. The most of the remaining slides you have. Some of these things are in your packet in larger format, but most of the rest of the slides have to do with the additional data and additional particular programs and ways, our home visiting program and others, around how we are in practice taking what we're doing, measuring, indicating, evaluating, so that it impacts service delivery: the way we screen, the way we develop treatment plans, and the kind of systems bridges we're building to make that difference.

Mike Foley: [07:21:58] Good afternoon. My name is Mike Foley and I'm the Director of the Michigan Children's Trust Fund. And the Children's Trust Fund has been around since 1982. We were lately only established and our focus is child abuse and neglect and prevention. And primarily the things that we do are that we have a blanket of

child abuse councils throughout the state of Michigan. There are 73 of them, and among them geographically we cover the entire state with a variety of services that our councils do. Additionally, we have a competitive grant process where we fund, really kind of a secondary the at-risk family services and supports, which we call direct services grants. I also serve as the chair currently of the board of directors of the National Alliance of Children's Trust and Prevention Funds, and additionally our trust fund is the PCA chapter in Michigan. To not get into a lot of detail there, but I did want to share that both the National Alliance and PCA intends to provide you with written testimony, and it will be a collaborative effort among our national networks to give you the best information that we can on the protection of children and the whole issue of child fatalities.

I'd like to spend my time here just making a few comments about prevention itself. I know my time got cut down a little bit here so I won't get into a lot of the data because it was mentioned quite a bit in the last panel. First of all, we know that children who are abused and neglected are at higher risk of fatalities. So without getting into a lot of the detail, I just want to set that as the standard, and because we know that we are fundamentally of the belief that we've got to do a better job of prevention. We've got to keep these kids out of the system and we have to provide their families the kind of supports so they are not only not in the system but they are not abused and neglected and they get that kind of nurturing and support that they need to realize their potential and again not be abused and neglected.

What I would like to say about that is that the good news is there's been real breakthroughs in prevention. We've talked a little bit about home visitation. I actually have a couple of comments but I won't say them now, and hopefully in the question and answers because I know some of the issues you've brought up about home visitations I have a couple of thoughts about. Home visitation is an excellent preventative mechanism. The protective factors work that come from the Center for the Study of Social Policy, I have made an analysis of all of that. I always have to look at them because I will forget one. But resilience, parenting knowledge, social connections, concrete support, and the social/emotional health of kids that … all of those. We know they are research-based and that if we do a good job of providing families with the services and support and we wrap those protective factors around them, that we can make a difference in child abuse and neglect.

Programs in Michigan like the safe sleep work that we talked about. We have a special initiative in southeastern Michigan and in shaken baby where we use the Period of PURPLE Crying, and again it may be an anomaly, but we have seen some really excellent results with that work in southeastern Michigan in the past three years. So, again there are excellent programs. The point I guess I want to make about prevention generally I think here in the state of Michigan and across the country, is that we rarely have the resources to do this in a consistent way. What I've seen in Michigan, I've seen impressive initiatives that have started, bipartisan efforts where people have come

together and really put some money on the table for prevention. But at the same time, when budgets got tight, they seem to be the first things that got cut, and we've seen a lot of frustration around that.

I want to share just one little anecdote about a judge in Saginaw County. Prior to being at the Trust Fund I was the director of a statewide organization called Children's Charter of the Courts of Michigan, and we worked on a variety of issues related to kids in the courts. What brought them there and then also the things that were at risk of bringing kids into court. We are a 501(c)3 organization, so we're constantly chasing money. And I had gone up to Saginaw to make a presentation to United Way up there, and as Dirkson said, "All politics is local." So it was all local decision making, United Way local, so I looked for someone to come with me and Judge Faye Harrison who is still a sitting judge up there agreed to come and make the presentation with me.

And so I got there and she wasn't showing up, and I was becoming tremendously nervous because I thought I was going to start doing shadow puppets or something because she wasn't there. Well she finally showed up 10 or 15 minutes late, and when she walked in I could see that she was really exercised and just really concerned about something. And as she sat down and we shared, what she said to me was that she was late because she just finished a termination of parental rights proceeding involving a young mom with a 3-year-old and a 1-year-old. And what she said to me, she said the situation had devolved to a situation where the termination was the only place that they could go. And then I remember her just looking at me with fiery eyes and she said, "But I want to say one thing to you as a state-level advocate." She said, "I am absolutely convinced that had that young mom at the point she had that 3-year-old and at the point she had that baby, had she'd been connected with the kinds of services and supports that would have made a difference for her, like a mentor that would help her make some decisions that were bad decisions as she moved on. Just teaching the importance of attachment and bonding and connecting with her the things in the community that were important to her," that she wouldn't have been there that morning making that termination of parental rights proceeding.

I give that example for a couple of reasons. One is because there is a lot of frustration throughout the state of Michigan that people are on the front lines doing this work and I think that is indicative of it. I also think it's a good example of the recommendation that we would like to make to you, and that is that we need a cohesive, comprehensive, and sustainable approach to prevention. I know I am running out of time and there are some thoughts I would like to say about each of those modifiers of prevention. It has to be cohesive, and some of that relates to what Director Corrigan talked about, silos. We need to have ways to bring things together in a meaningful way. It's got to be comprehensive and again sustainable. Prevention can't be those services that we lose the first time budgets get tight. There's got to be a commitment to that. So again, that's the fundamental recommendation, and as I've said, both PCA

and our National Alliance will have more to say when we provide you written testimony. Again, thank you for the opportunity to speak today.

Kaitlin Ferrick: [07:19:39] Good afternoon. My name is Kaitlin Ferrick and I am the Head Start state collaboration office director of the Office of Great Start, which is an office in the Michigan Department of Education. In my role, I am charged with facilitating partnerships between Head Start and Early Head Start grantees and other state and local entities, both private and public, that benefit the population that Head Start serves. In my office, the Office of Great Start is a fairly new office. I am the center of our little context. Because it has been spoken about by some of my other fellow speakers, one of the criticisms of state government is that we often operate in silos. And so Office of Great Start was brought together through an executive order in 2011, and it brought together my office, the office of Child Care Development Fund, which is in charge of managing child care subsidies in the state of Michigan. The office that also manages the Great Start Readiness Program, which is Michigan's state Pre-K program for low-income children at 250 percent or below the poverty line. Also Early On, which is the Part C program for Michigan, which is the federal early intervention program and the Federal IDEA Act. Also involved in the Office of Great Start is the after-school program for Michigan. And really what I want to speak about today is the importance of investing early as a method of prevention of child abuse and neglect and investing in quality and as well as child care and early childhood experiences, as a method to help reduce child abuse and neglect.

Early Head Start and Head Start are federal programs that serve children ages 0–4. In Michigan, we have about 5,700 children enrolled in Early Head Start and 37,500 enrolled in Head Start. So it's a large population of children. There's been a lot of talk about, I'm sure everyone's heard it, about how the effects of Head Start wear off by the time a child reaches second or third grade as far as academic achievement, but there is a lot of research that shows that Head Start and Early Head Start do benefit children who do attend in regard to self-help skills, social/emotional well-being, and other sort of really positive social and emotional outcomes, especially with regard to Early Head Start. As many of you know, funding for programs that benefit children ages 0-3 are underfunded. There are huge waiting lists for Early Head Start and many of the other programs that do benefit this young population, but there was a large multiyear study that was 13 years of data for over 1,200 children that really showed that children who were enrolled in Early Head Start were much more likely not to become part of the child welfare system than their counterparts who did not take part in the program. And many people ask why that is, and it really seems as though this lowers risk factors and creates a trajectory for better parenting. Early Head Start takes place in a variety of modalities—both home visiting, which I know was discussed earlier, and center-based. Also, placing Early Head Start-eligible children in child care homes. And there's really a focus not only in Head Start but really across the programs that the Office of Great Start funds and manages on including parents as their child's first teacher.

And so, I think a lot of times we talk about early intervention, and center-based is also an intervention that people don't often consider. A quality program can really lower the likeliness of neglect, provide parents with respite, and also improve child communication skills, which also helps them to communicate to others if they are experiencing child abuse or neglect. Also, Early Head Start is shown to improve positive caregiver coping and parenting skills, as well as interorganizational awareness and communication.

I would also like to say that with child care, I really feel as though...I heard someone speaking earlier about child care providers who work at homes … and here in Michigan we have a system called Great Start to Quality, which is Michigan's tiered rating system, and programs are rated on a zero to five star basis, based on a variety of indicators. And part of the training for anyone who is part of the system is that they are trained on child abuse and neglect. And that includes unregistered and unlicensed child care providers. They are also mandated, even if they are not going to be part of the quality rating system, even if they are not going to be part of licensing, to take this training on child abuse and neglect. And this was sort of surprising to those who work in the child care subsidy arena because this was something that really came from the unregistered providers themselves as something that they wanted, and typically the unregistered/unlicensed providers are also known as "family, friend, and neighbor care," and so they're generally related or have a close relationship with the parent whose child they are watching, and this is something that they really wanted, and sort of empowering those people to really understand what child abuse and neglect looks like, and this is really important because in Michigan most of our very low-income children are in these settings because child care is very expensive, and so I guess what I would like to leave you with is the importance of investing in quality for all provider types, and understanding that family, friend, and neighbor care and Early Head Start, Head Start really do serve an important purpose for the most low-income children, and their families need more support than others would.

Blandina Rose: [07:26:23] Good afternoon everyone. My name is Blandina Rose, I'm the Project Director for Detroit Promise Neighborhoods, and I'm going to talk with you about Promise Neighborhoods as a place-based initiative that can help support the direction of certainly reducing child care infant mortality rates and reduce abuse and neglect. Where children live is the strongest, most important indicator in predicting and understanding child abuse and neglect. Followed by the fact that Promise Neighborhoods does promote comprehensive solutions and finally we need right now to know how to prevent, engage, build relationships, and really have real-time data. So let's just jump right on in.

One of the first things I want to share with you is that we need to put a face to this. This lovely young lady on the screen is Tamara Greene, lost her life at age 8 by the hands of her mom. There were plenty of indicators that talked about Tamara Greene before she actually died. There were opportunities for actually addressing issues even

before that. I'm assuming that you saw a lot of statistics today, so I won't really talk about many of them, but since we are talking about Detroit's Promise Neighborhoods let me just share with you a couple of things. In one of Detroit's Promise Neighborhoods, the Osborn Community, crime rates have gone down; however, domestic violence has gone up. High rates of abuse and neglect as you have seen and we have seen correlate very highly with exceptional poverty, domestic violence, and joblessness. So we see this as something that really requires a comprehensive approach. Just to share a few things with you about Detroit's Promise Neighborhoods communities, Osborn is on the eastside of Detroit, Clark Park is on the southwest side. One community is heavily African American; the other is heavily Hispanic. Both of them have very similar statistics regarding both abuse and neglect.

Promise Neighborhoods is both evidence-based and data driven; we address 19 indicators that we deal with. We have over 35 partners, and we have a master data-sharing agreement where all partners agree on real-time data, another thing that you probably need. These are our 19 indicators. One of the things I would say about those 19 indicators is that the last four are specific to Detroit. But all are critical to the work that we are doing because once again we take a cradle-to-career approach. So we have four indicators that are directly related to early childhood. In the last year, we addressed age-appropriate functioning through a partnership with Great Start and the Promise Neighborhoods, the city of Detroit Health Department, and a number of other partners, and we were able to identify in some cases where children were experiencing both social and emotional distress and other areas of distress. Those can be the first indicators where we know that we need to follow up with additional support for families. One of the things we need to do using Tamara as an example is to set priorities. If we're looking at priorities, the lowest priority might be mothers expressing a fear of abusing their children or a child showing a fear of being abused. Maybe on the far end of setting those priorities, and where we really need to be moving, is all of the above in the history of child protective services having been an issue leading up to that particular point.

Tamara was probably at number four or number five, evidence of physical abuse or neglect. Able to be seen by any number of agencies that knew her and knew her mom. There are many ways to respond as you can see: we can collect better, clearer data, that's one thing that we certainly work on in Promise Neighborhoods. Our master data-sharing agreement allows for data sharing; however, we also know that along with data sharing we have to make sure that we speak a similar data language. Nevertheless, without a clearer agreement on all language terms, we do continue to collect data, and that is the most important aspect of it.

Improved interagency communication, you see the others and then identify causes. You can see that history of parents being abused is certainly a cause we already know about. Crisis at home. Unemployment is a huge one in Detroit. You can only imagine unrealistic expectations of a child, which say to us that we need to help them with

their parenting skill as early as we can get to them. Social isolation is also huge. We think that most young parents should certainly have a support system. They don't all have that. In fact, many of them do not have anything, and they really need that support system. Certainly a history of substance abuse can be critical and many parents are just overwhelmed.

We've got lots of prevention data that you already know about, but if I were to say that we needed to do something to prevent this, one of the first things that I would say is, "remember who the perpetrators are." You see that moms are the highest, followed by dads, followed by moms and dads together. You see the profiles in their 20s, below high school completion rate, below poverty rate, depressed, and other stressful issues. I will go back and say, abuse is usually occurring by fathers and boyfriends, whereas neglect is usually occurred by mothers, so not always but certainly in some cases. One of the things that we really know that prevention requires is on the ground, where families are: focus on the parents, connect, relate, support, report, address systemic barriers. That's what we're here to talk about really today and just move on all of those behaviors. I could talk about some of the things that we did last year, but you get the idea. I think the most important thing is we take the holistic approach. We absolutely believe that one size does not fit all. One agency does not fit all. One need does not fit everybody's needs. I just wanted to share with you this is partner work. We partner very broadly. You see the Promise Neighborhoods comprehensive early learning network. They meet monthly. They talk about every issue under the sun—how to address it and how to really meet it at its most critical and most cutting-edge level.

So I end with three recommendations: Number one is to appreciate the power of meeting and respecting families and their realities where they live, their everyday lives. Secondly, establish accessible, affordable quality relationships and services, and partner with families to get them the help they really need. And then finally, find and support systems that are friendly, realistic, and respectful. We tried to develop that model in Promise Neighborhoods, and we absolutely must collect data with fidelity and share and with discipline and share. Thanks.

Stacey Tadgerson: [07:35:00] Good afternoon. Thank you for the opportunity to present to you today Commissioners. I am very honored to be here to present on behalf of the tribal consultation strategies that we've developed in Michigan that will also address our child welfare performance and services here in Michigan. Okay, American Indians are a disproportionately affected population for child abuse and neglect and/or potential fatalities, based upon high risk of victimization. They experience violence more than two times the rate of the nation. Infant mortality is 12 per every 1,000 live births, and there's a 39 percent domestic violence rate, which is highest in the United States presently. As well as other high risk factors of poverty, substance abuse, lower education, and other health indicators. The Indian Health Service in 2005, 2007 population survey revealed that American Indians and Alaska

Natives have large families, less health insurance. The number of American Indians without health insurance is over double that for the United States compared to all races, and a poverty level of nearly twice that of the rest of the population. Furthermore, studies indicate that American Indian and Alaska Native youth experience bullying at rates higher than youths of other races, 27.5 percent compared to 20.1 percent.

American Indians and Alaska Natives have government-to-government relationships with federal and state governments based upon executive orders, laws, policies, and treaties. Programs and services that the department provides specifically to American Indians, Alaska Natives are not race-based, they are respective to the legal agreements established by federal and state governments with the tribal governments. Members of tribes have full access to services as tribal, state, and U.S. citizens. Government-to-government relations between tribes and states and tribes and federal governments are implemented through tribal consultation plans, agreements, and meetings. Tribal consultation is vital to the collaboration between federal governments and tribes and likewise for state and local governments and agencies. Examples of tribal consultation requirements that are applicable to social services include Title XX of the Social Security Act for child welfare programs pertaining to Indian child welfare, as well as presidential executive memos requiring state government agencies to consult with the tribes minimally annually, as well as agencies within their states. And at the state level, governors have authorized executive directives pertaining to tribal consultation of state departments.

In Michigan, we've made diligent efforts to bridge the gap between state and tribal services through tribal consultations and program-specific enhancements. During the current administration, Governor Snyder has authorized Executive Directive 2012-02 pertaining to the state department tribal liaison and tribal consultation. These are available in the state of Michigan and the Office of Native American Affairs website for more information. These are our 12 federally recognized tribes here in Michigan at this time. We possibly will have 13 in the near future. Grand River Band has their application under administrative review at the Bureau of Indian Affairs presently.

Overall, through the tribal consultation plans and agreements implementation, there are six systematic strategies the department, in collaboration with tribes and Michigan, have implemented most recently in assisting with prevention of child abuse and neglect fatalities that I will highlight this afternoon. The following slides will give more detail of these six topics here. First is leadership commitment to conducting tribal consultation meetings in tribal communities. Director Corrigan has been instrumental in the application of this particular strategy. In 2011 when she came on board, she signed eight tribal consultation agreements with our tribes, designating the initiative of the department to collaborate with our tribal partners in their communities to develop the strategies that are necessary to provide that collaborative partnership to identify and provide services to vulnerable populations.

These slides also demonstrate the meetings that we conduct with our tribes. As you may imagine, the volume of topics covered with each tribal meeting is extensive and provides ample opportunity for addressing safety, permanency, and well-being issues. As an example of some of the topics that are covered in the meeting.

Strategy two is hiring administrative professionals, American Indian and Alaska Native professionals, to provide services to tribal nations and clients. The department currently supports two levels of American Indian staff and services: Native American Affairs, providing statewide administrative services, and Indian Outreach Services, providing client-level services at the local office level. This is where they are located throughout Michigan. We have 83 counties in Michigan.

Strategy three includes developing data. We have discussed MiSACWIS today. The Michigan state automated statewide information system, and many of you know this went live April 30. MiSACWIS also has ICWA, Indian Child Welfare Act, and Michigan County Preservation Act sections with demographic tabs to capture American Indian and Alaska Native data. We provide those quarterly reports to our tribes in regards to enhancing services to those populations. Those reports are basically from the state side. That information that's collected, tribes have their own social services program and their own data collection. They do not necessarily share that with the state, and so we currently have 250 children in state care, presently across child welfare systems for both in-home and out-of-home services.

Very quickly, we have a couple of minutes. The next couple of strategies that we've implemented include developing state-specific laws to protect Indian children, and culturally competent policies, procedures, training, as well as resources for staff and clients. And then we've also developed culturally competent. So we've also developed contracts and agreements that provide services to American Indian/Alaska Natives based upon their special needs. Currently examples of that include a special contract for public service announcements that targets safe sleep for tribal communities. In addition to that: memorandums of understanding for youth in transition; set asides for tribal communities for those children that are in the tribal court system, so there is money that they can access; Chafee dollars; as well as access to in-home intensive services for family preservation, Families First.

And then finally, what I'd like to share with you today is in regards to the fatalities. There were no American Indian/Alaska Native fatalities in the state of Michigan from 2009 to our last data point in April 2014. We are very thankful for that. But what we would like to say is that the state does not have the information of any children that were brought to the attention of the tribes and the tribal systems. And so our final recommendations for the Commission would include, if that data gap is evident nationwide, that recommendations be sought for demonstrations from the Bureau of Indian Affairs, the Department of Justice, and the Administration for Health and

Human Services for Indian Health Services around American Indian/Alaska Native fatality data sets and data requirements that the tribes submit federally.

In closing, there is additional information that was provided by the Michigan Department of Community Health that's in your packets that was provided by our Tribal FIMR Project here in Michigan. We talked about FIMR earlier today, that information is available to you and then these are also our final examples of what has been generated out of the tribal consultation strategies. We developed ICWA alerts, as well as best practice models including local multidisciplinary teams for tribal protocol. I thank you for your time and attention today. This was not the correct presentation so I'm not sure what information they downloaded. So I do apologize that some of the information is skipped, and we can make sure that they have the right information. Their packet is different. The handouts are different than what they downloaded. Okay. Thank you.

Chairman Sanders: [07:44:27] We have a few minutes for questions from Commissioners. Commissioner Covington.

Covington: [07:44:31] Mr. Foley, will you tell us your ideas on the home visiting that you didn't think you had time to share. I'm really intrigued.

Michael Foley: [07:44:38] Well I just had a couple of thoughts. There is no magic bullet on that, but one of the things that struck me when you were talking with a prior group about home visitation is that yes, home visitation as just a service in itself is not going to be the effective strategy that it needs to be when we're talking about the families that, Commissioner Petit, that you were talking about. I used to be the Healthy Families America state leader for Michigan and worked a lot with the folks on the front line doing these home visitations, and over a period of time it became known as the Big Three: the issues of mental health, substance abuse, and domestic violence. When I think about a home visitor that goes out, and there are things that a home visitor obviously can do. You know, teach the importance of attachment and bonding and making community connections and a variety of things and just modeling good parenting. There' are a lot of effective things that a home visitor can do. But by and large, he or she is not going to be equipped to deal with a serious domestic violence situation or mental health or substance abuse, and so home visitors, I think, need to be trained to kind of be able to sensitively address that when they see it and then it goes to the public health piece. I think there's got to be a commitment at the front end of, you're going to have this home visitation program knowing that you're going to run into these extremely high-risk families, and have a community collaborative agreement that a home visitor is going to have the capacity to make a referral to domestic violence or make a referral to substance abuse or mental health or whatever, and have the prior commitment that there's capacity there so that can happen. Because I think, often times I think home visitation is just seen as that silo,

but when they're extremely effective is when that kind of public health approach to connecting with other services in the community are set up ahead of time.

One of the examples that I would point out to you that I'm aware of is that in Massachusetts I know that they've done some work like that. They have a fair amount of commitment to home visitation there, and I know they've done some work to connect to some of those other services. That was just one thought as I was listening to the prior conversation that I'd like to share.

Chairman Sanders: [07:46:48] Commissioner Martin.

Martin: [07:46:50] Yes, thank you very much. The panel was very informative. For the people who presented to the Commissioners information about preventive measures by looking at the history of abuse and neglect with that same family in the past, have any of you separated out abuse and neglect from prior deaths? So if a family had a prior death of a child...have you separated those out? Do you understand what my question is?

Bladen: [07:47:22] Right, so for the Birth Match system those families would be included if they've had a prior death. It could be one that, so primarily the list includes families with prior terminations, but we manually add other families to that list and those would include families who had a prior death of a child that was a result of abuse and neglect. Even if they didn't have their rights terminated. So maybe it was their only child, so we have the ability to add that, and then of course know that and have that trigger the CPS alert.

Martin: [07:47:54] And when looking or examining the cases where there was a prior death, do the risk factors look vastly different than cases where there was not a prior death? So it was just abuse and neglect.

Bladen: [07:48:09] I would say, no. Without having the data right in front of me to show me what those risk factors are, but having worked in this area and having reviewed over 100 fatalities in my work at the Ombudsman Office and as Director of Family Advocate, I would say no. I would say that they looked very similar. Severe injury cases look very similar to death cases.

Martin: [07:48:31] But simple … and I hate to use the term "simple abuse," because I don't want to diminish it, but a simple abuse case, is it a matter of degree of the actions or omissions, or is it that there were more risk factors?

Bladen: [07:48:50] I think it's multiple. I think you have to look at the child characteristics as well as the family characteristics. So those you would have to look at the entire family picture. If it was a child under 3 who presented with a complaint of physical abuse, that is a huge predictor. It may have been only once—huge predictor of future fatality due to abuse. So it depends on a variety of factors, and we want the

opportunity at Children's Protective Services to be able to identify those risk factors, put the picture together, and then make a better decision about what intervention is necessary to protect that child.

Chairman Sanders: [07:49:29] Commissioner Dreyfus and Commissioner Petit.

Dreyfus: [07:49:50] Two questions. On the Birth Match System you talked about, I don't have the data sitting in front of me, but the number of matches that were made, of those how many actually were seen, went out and an investigation was done, and of those, what interventions occurred? Do you have any data that says what happened to the children that were screened out in terms of, was there ultimately a death or a serious incident?

Bladen: [07:49:57] If you looked at 2013 you would see 1,120 where there were matches made. We went out and investigated 442 of those. So if I understand your question, you are talking about the 700? So those must be sent to Children's Protective Services; however, that discrepancy represents poor matches or cases that were already investigated. So for example, Birth Match is supposed to trigger an immediate complaint to CPS so that CPS can go out, but sometimes the hospital is delayed in reporting their birth data to vital statistics, and that's the trigger. The report coming into vital statistics is matched with our CPS data. So when that delay happens, and our staff already goes out because maybe the hospital called, but these are cases we are going out on. It just means that the Birth March didn't trigger the investigation. And it's probably not clear. We are weeding out very few.

Dreyfus: [07:51:04] So my next question is on federal financing, because obviously we are trying to influence more than just child welfare funding streams, and I think about Medicaid and I think about TANF. Very few people in any of our hearings have really talked to us about the one thing that people bring up over and over again is poverty and the need to increase the income in households. Right? I'm over simplifying here for this purpose. And I also hear people talking about mental health and substance abuse, the social determinants of health, and we are in a time of rapid health care reform and the need to be thinking about our Medicaid policies in terms of our state plans and federal allowable costs, things like that. Where are you starting to think about the interfaces between TANF, Temporary Assistance for Needy Families, whatever your state calls its Welfare to Work program, and Medicaid, and where those policies are connecting or disconnecting in your ability to prevent and intervene early?

Bladen: [06:52:18] I think those conversations, we all recognize that they must go on and I think, I know from the Medicaid side, honestly, initially just trying to launch our expanded Medicaid population that we had to do under the ACA and so on is taking precedence the last year, so to kind of get that up and running and so on. That said, I had a meeting this week where we are talking about these very things and the need to … now that more people have health coverage and so on, and it brought some of

those, at least potentially, risk factors down in terms of an increase level of coverage; how do we better connect these systems. I think that not yet do we have a model where we can really speak to, "this is an effective way to do it." Director Corrigan may have additional comments that she wants to make on the ground. We don't have something yet that we could point to, but those kinds of connections are very much going on. Where we're probably talking more now is in the area of the home visitation, given the blend of federal funds down to all three different departments around how home visitation is funded in Michigan between the Department of Education, Children's Trust Fund, the Department of Human Services, and we have Medicaid funding streams, we have general funding streams in Michigan for home visitations. Interestingly enough, one of my staff has been invited this next week to participate in a conversation that includes HRSA, CMS, and I believe the Department of Ed is being convened by HRSA. Those discussions aren't going on federally and certainly the recommendation that you've heard over and over again today about aligning the kinds of outcomes, aligning how those funds can work together, is important. And very much so in this arena of what you said is the work and the health care piece.

Chairman Sanders: [07:54:29] Thank you. Commissioner Petit?

Petit: [07:54:31] Returning to the Birth Match question. We could also frame it possibly as a pregnancy match or in utero match, and what we know is that a lot of temperament is shaped in in utero. A lot of future health conditions may be shaped within utero. So is there anything in Michigan that makes a connection to the first health professional that a pregnant woman typically sees, which should be an obstetrician not a pediatrician? Are there any programs in Michigan that link this notion of previous involvement, say with CPS, now that there's a new pregnancy? I'm familiar with one case in which eight babies were born to the same mother with fetal alcohol syndrome, and the ninth the government attempted to step in the case and basically confine … I'm not suggesting anything at this point. I'm just asking the question of, given the fact that there is repeat pregnancy frequently within households where there is a history of abuse and neglect, is there an attempt to hook up and match up with those families during the pregnancy, and then once born in the obstetrical unit I've been to many of them in which the nurses in the obstetrical unit will say, there are mothers here that should not be taking a child home. Is there a process at Michigan Hospital with CPS or public health or whomever, whatever the least intrusive is, that signals the fact that this mother is not bonding with the child. The range is inadequate, etc. Is there an intervention at that point that can take place?

Bladen: [07:56:13] You're absolutely right in terms of those focus areas. We don't yet have the link data system other than in the Birth Match area, where we truly can look at that broader history combined with the health history of the multiple pregnancies and so on. An individual obstetrician, for example, does not have access; the health system does not have access to knowing what that protective services history is like

we formally do in the Birth Match system. This was kind of started … it didn't feel low-hanging fruit at the time, as a way to get started to prove why this is so important. That said, we work a great deal through our home visitation programs. Through our Medicaid health plans in terms of their expectations for the obstetrician and practitioners in their system to … not only do they know their mandated reporters but to be very sensitive to these issues and to collaborate. In a number of our home visitation programs, particularly our state-run one, if it's a mother we are aware of through either data sharing or, because we don't have a formal way to share that data yet, that there is involvement or has been involvement with Children's Protective Services, that becomes part of a necessary part of collaboration.

Petit: [07:57:40] I want Mr. Foley … with women who are pregnant and have not yet given birth, do you do home visitations in those situations?

Bladen: [07:57:52] Yes.

Foley: [07:57:54] The whole visitation programs that are funded by the Affordable Care Act, depending on the model, I'm assuming that home visitations are being done. We fund direct services grants, some of which are home visitation programs, so as a blanket I can't say, yes, all of our home visitations programs do that. Depending on the model, some of them do.

Petit: [07:58:15] During pregnancy?

Bladen: [07:58:17] Yes. Michigan is one of the few states that has an in-home visitation program that is evidence-based by Michigan's state law definition that it's an entitlement for Medicaid women. It is a state plan-covered service. It begins the moment they are identified as pregnant and choose to enroll in the program. We do a great deal of outreach; we don't yet have all Medicaid women enrolled, but we're working very hard toward that goal. Over half the births in Michigan are Medicaid-covered births and so reaching that population, we serve in any given year now around 30,000 women and infants in Michigan with that program. And that program lasts through the infants' first, in general, first birth date. The prenatal focus, we do a risk assessment. All the women are titrated by low, medium, and high risk. They are prescribed interventions and so on relative to what the risk areas are. Domestic violence, child maltreatment, those are risk areas that are identified as part of that work. Therefore, it becomes part of the required coordination for that program because it addresses that, along with the more traditional prenatal care and those kinds of things.

Chairman Sanders: [07:59:38] So we're going to finish this panel. That was really very informative. Thank you. It was left with a number of questions and not enough time, but we have one final panel to present so we're going to ask them to come up as you are leaving. Thank you so much.

[*Applause*]

So I'm going to call up Renée Canady, Frank Vandervort, Carol Garagiola and Cheryl Polk. They'll each present for 3 to 5 minutes on any final issues that might be of help for us as we look at reducing and eliminating child abuse and neglect fatalities. We will start with Ms. Canady.

Renée Canady: [08:00:37] Thank you. It's an honor to be before you today, and I am especially honored to be here as the relatively new CEO of the Michigan Public Health Institute. But I also come with my history as a health disparity researcher at Michigan State University, a local health department health officer, a consultant with state health departments, state corrections, a number of experiences … but I want to share with you that the most important lens that I bring is that of a mother who buried her first son when he was 6 months old. And though his death was not the result of neglect or child abuse, I would just implore you that the death of a child changes eternally the family, the community, the state, the city, and this nation. And so I thank you for your service.

So in the interest of time, I think I just want to whittle down to two heartfelt recommendations for you. One is to implore you to integrate a health equity lens in your thinking. The state of Michigan has a very strong and robust history at the community level, as well as at the government and institutional level, of having very difficult conversations about disparities and differences across populations but also about gender oppression, about racism, about poverty… and each of those things can veil the key solution, if you're not careful. I was recently introduced to the idea of "difficult knowledge," which is a real concept that those in pedagogy are learning to talk about. It's not just that something is hard to understand, but that there are some events in the history of this nation that are so horrific that engaging them is best left reserved until the individual is at a place where they can receive the understanding and the impact of the difficult event.

And so I would submit that you are dealing with difficult knowledge, and the horrific outcomes when you compare what we've accomplished or failed to accomplish as a nation with other nations who seemingly have much fewer resources then we. And so in that interest of grappling with difficult knowledge, we have used … Margaret White has a definition—I am going to read that to you real quickly—of health equity, which is, "Health inequity:" she defines as, "differences in population health status and mortality rates that are systemic patterns, unfair, unjust, and actionable as opposed to random or caused by those who are ill." That has been used by our state health department in our discussions around infant mortality. It's been used in a partnership with several county, local health departments and community organizers to address social determinants of health, but it has given us a charge to push forward. So with that, we think of our health equity lens as doing our work in a way that seeks out what is unfair. And that is a value-laden term. And so we've given ourselves permission to

not be neutral on this. And so seeking out what is unfair in order to reverse it or avoid it. We aspire to apply justice, and that is helping families realize their potential in this nation, in this state and community.

The third part of a four-prong lens is recognizing the impact of social resources on behaviors, but fourthly also recognizing the impact of social opportunity. And so the choices people make are determined by the choices people have, and so it's not always they won't do the right thing, they are not able to do the right thing. And so there is another opportunity that you might avail yourselves of, and that is the upcoming release of the *Raising of America*, which is a California endowment series that's being produced under the leadership of Larry Adelman, coming out this fall. The Raising of America.org, they have some clips on there now. But it is a way that we've begun using to think about these very challenging topics.

The second recommendation I would submit is while I recognize it is important to intervene immediately. You need some low-hanging fruit and some immediate solutions. Please don't hang your hat there, because if you do I would submit that 20 years later we are going to be right back here having these same conversations. As a public health professional who battles the impact of racism and discrimination in health outcomes, I do it one, because I'm relationship-driven but two, I don't want my college-attending sons to have to come back and start all over again because our generation couldn't get it right. So, there are things that are immediate and there are also both long-term things that we simply have to take a different turn on. And those are the harder ones. Those are the most policy-driven ones. Those are the, "we've always done it this way." And so I would submit those two things and thank you for your attention and for your time this afternoon.

Chairman Sanders: [08:06:29] Thank you very much. Mr. Vandervort.

Frank Vandervort: [08:06:30] Thank you for permitting me to address the Commission to Eliminate Child Abuse and Neglect Fatalities and to represent the American Professional Society on the Abuse of Children here today. APSAC is a national and a professional organization focused on supporting professionals who serve children and families affected by child maltreatment and violence. In the interest of time, I think what I'm going to do is not read all that I have prepared. I submitted copies of that when I came in this afternoon and I understand you'll get them after the meeting today. But I'll just touch on a couple of highlights.

First of all, APSAC would recommend that we put into place aggressive and improved data collection systems. We do not have the capacity right now to collect and to utilize the data that we must if we're going to stop child fatalities.

Second, we think it is essential that we secure and invest more resources in effective prevention. Everyone I think here this afternoon that I have heard has mentioned that, and I'm in agreement, so I will not focus on that too much. We think that it is crucially

important that the public generally, and that policymakers in particular, be made much more aware of the centrality of early trauma, toxic stress, and especially neglect to lifelong dysfunction. I've been a lawyer for 25 years doing child protection work in one fashion or another. Before that I was a social worker doing it, and for almost 30 years now I have repeatedly heard neglect discounted as a problem in this country. Neglect is in many ways much more problematic than abuse is, and the general public doesn't understand that and many of our policymakers don't understand that. That's essential.

Next, agencies like the National Center for Injury Prevention and Control, which has a focus on preventing violence to children and youth, must be fully funded and must treat child abuse and neglect as a national health emergency on par with cancer or heart disease. I've been struck in the last couple of weeks by the enormous conversation in this country around Ebola. We need that conversation around child abuse deaths. As many children die annually in this country from child abuse and neglect as have died from Ebola. And I haven't seen one single media report about that, but every day there's panic about Ebola. We need that kind of focus on child abuse fatalities.

We must invest resources and build alliances and partnerships with education, health, business, and faith communities for the purpose of supporting primary prevention. Today it's a wonderful opportunity for us all to get together, but we're preaching to the choir. We all know what we've talked about today; there aren't any mysteries here probably. The folks in the business community, they don't know. The folks in education, they don't know. The folks in the media, they don't know. We've got to have those collaborations. We cannot do this by ourselves. We must provide universal parent education for every single new and expectant parent in this country, full stop. There is nothing more to say about that. We've got to do it. We must adequately fund home nurse visiting program. It's not a perfect program, but it's an evidence-based program that has shown real benefits. And I would also say that part of the problem with some of the studies in nurse home visiting or home visiting generally is that we have polluted what we know works. Right? We don't fund the program that we know works. We underfund it, so we use paraprofessionals and we use other folks. If we're going to make an impact and you're going to stop child fatalities, one thing we can do is fully fund that program the way it's designed so we have program fidelity.

I asked that each of you receive a copy of a case recently decided by the Michigan Court of Appeals called In the Matter of Lane/Boggs Children. I hope you've had an opportunity to read this case. But I will briefly summarize the facts. This case involved a mother who had eight CPS referrals between April of 2006 and January 2013. Four of those referrals were substantiated. During that time, she gave birth to four drug-exposed babies and admitted drinking as much as a pint of alcohol a day throughout her pregnancies. The mother was repeatedly provided family preservation services for substance abuse, domestic violence, mental health, and parenting problems. Time and

again she failed to complete services or failed to benefit from services, and still we preserved her family. Then not surprisingly, one of her children died when she was co-sleeping with a baby after using drugs and alcohol. I would like to say that this case is an aberration, but I can't.

In my involvement with Michigan's child death review state advisory program since 1999 teaches me that this is a pattern all too frequent. Every year we review a dozen cases with very similar facts. Last year for example, we reviewed a case in which a mother had 16 CPS referrals in three years of almost continual in-home family preservation services. The 17th referral involved a child who died when her mentally ill, drug-addicted mother failed to respond to an apnea monitor signal that the child was having trouble breathing. As these cases tragically illustrate, we must do a better job assessing families' capacities to meet their children's needs once Children's Protective Services agencies become involved. The Children's Bureau has recognized the critical importance of assessing families, and the AFCARS have made clear that most states do an inadequate job of this vital task. This Commission should make two recommendations regarding assessments.

First, APSAC urges you to recommend universal use of valid and empirically supported assessment tools, such as the Structured Decision-Making tool developed by the Children's Research Center of the National Council on Crime and Delinquency. Everybody should use that. But use of this tool by often inexperienced, overworked CPS workers—while that's necessary—it is not sufficient to protect children. We should also make multidisciplinary teams a reality on the ground. The Child Abuse Prevention and Treatment Act, specifically 42 United States Code, Section 5—

Chairman Sanders: [08:13:24] Mr. Vandervort we're going to also have to ask you to wrap up.

Vandervort: [08:13:27] I'll do that. CAPTA requires that we have multidisciplinary teams. Michigan has a law that requires multidisciplinary teams. It's on the books, it's on the ground. We need it on the ground if we're going to stop child deaths. We have to have a functioning multidisciplinary team in every community to help CPS with its work. Dr. Fowler at the University of Michigan published some very interesting research where she showed early comprehensive assessments of families working with CPS has better outcomes for children. No child deaths. More children stay at home than get placed. They get the services that they need, and when children are placed, they are in foster care for a shorter period of time. Thank you.

Chairman Sanders: [08:14:15] Thank you. Ms. Garagiola.

Carol Garagiola: [08:14:19] Good afternoon and thank you for your very obvious and intense attention this afternoon. It's an honor to be able to speak with you. I'm going to speak as briefly as I can about an issue that has been brought up this afternoon, and that is the need for institutionalized and supported court and community systems'

collaboration for the purpose of preventing child maltreatment and fatalities. The perspective that I'm brining here is I currently work as a project director for the Michigan Domestic and Sexual Violence Prevention and Treatment Board, which is housed in the Department of Human Services. I am a relatively recently retired probate and family court judge, and I had the honor of being colleagues with Judge Martin in the National Council of Juvenile and Family Court Judges Model Court Program. I'm going to talk about that model-court program. I am also a former prosecutor, and I do then have a vantage point of an insider's perspective of multiple court systems. Today I'm actually here as a representative of the Governor's Task Force on Child Neglect and Abuse. I do have the privilege of serving as a designee of Director Corrigan on that. That task force is a model of institutionalized state-level collaboration for the purpose of child welfare system improvement. Work at that task force has included, among many other programs, updating modern protocols and developing modern protocols for coordinated investigations at the local level and coming up with a comprehensive initiative to ensure implementation of these model protocols at the local level.

I'm partnering with our State Court Administrative Office that does have a wonderful Child Welfare Services Division for supporting cross-system training for child welfare systems professionals. The Department of Human Services is a key partner in this institutionalized state-level collaboration. You've heard today from Director Corrigan and others that she herself has crossed systems from the Supreme Court to lead the Department of Human Services. She has a clear understanding of the interdependent relationship among the Department of Human Services, courts, and communities for health, family safety, and well-being.

I have one basic recommendation, and then some recommendations about how to get there. Based on my experience and perspective, I would ask this Commission to support the institutionalization of state-level and local-level collaboration within and across court systems and community systems, with a shared and coordinated and consistent focus on child and family safety and well-being. And when I say institutionalized, I mean, built into our organizations and our operations of court systems and community systems. Not as an add-on, but as a way of doing business. Briefly, I'll just explain, clearly this Commission understands why. You are well aware of the complexity of the human conditions that bring children and families into the child welfare system. This complexity makes it impossible for one stakeholder or one state system to address this. Systems must work together with the understanding and respecting of separation of powers and distinct roles and responsibilities of the stakeholders in each system. There is a particular need for collaboration around identifying, developing, and funding best and promising practices, services, and interventions that are needed in the community to prevent child maltreatment and child fatalities.

I'm going to talk briefly about before children are involved in the child welfare system. And that is this collaboration, and again I include courts in this. Court and community collaboration supports early identification of the risks to child safety and well-being and prevention of child maltreatment by connecting children and families to appropriate and effective community services and systems of care. Courts and community systems representatives need to meet on a regular basis. Not just in response to a particular crisis. They need to identify on an ongoing basis the safety and well-being needs of the children and families in their community. This is a local issue, but it has to be supported at the state level and it has to be supported with connection to national resources. Local communities cannot reinvent the wheel but they are the ones that are going to make it happen at the ground level. At the local level, they need to meet to identify the gaps in services, to develop in the community and keep up-to-date best/promising practices and services. They need to allocate and share and maximize their limited resources to meet the service needs. They need to share information across systems, access needed services. They need to make their services as easily accessible as possible, and they need to develop a system of care that is effective and responsive.

The funding issues that have been brought up. Complexity is a funding issue, and we need help at the national level and the state level. So again, it doesn't have to be figured out at the local level. But at the local level, it does need to be understood. People do need to come together to share their resources. I also want to mention briefly that most of these children and families that I saw in court had been court-involved prior to their involvement in the child welfare system. They show up in our criminal justice system, juvenile justice system, child custody, child support across the board. And court responses are disconnected and disjointed. Each different court has its different response. And again, while each court system has its own purposes and laws and rules of procedure, once they are planning with X and conclusions of law at the end of the day these courts, all of them pretty much are in the business of solving human problems. And so across systems, across court systems we need to be looking at issues of child and family safety and well-being.

Just as an example, in the criminal justice system if you have an individual in there and the underlying issue is a domestic violence issue or a substance abuse issue, criminal courts don't tend to look at that in terms of family and child safety. There is no reason that interventions, us, should not go to that and have that opportunity for that intervention before involvement in the child welfare system.

Chairman Sanders: [08:20:57] Ms. Garagiola, you need to stop. Dr. Polk.

Cheryl Polk: [08:20:59] Good afternoon. I want to thank you first of all for allowing me to testify today. I'm not sure if I want to thank you for allowing me to be the last testimony you hear after a long day. But be that as it may, I also want to ask your indulgence, I want to submit my testimony in writing because so many of the things

that I've been, I'm old school, I've been writing this afternoon, I think I can send to you in writing.

Like many people before you, I should tell you how I came here today. I started my professional career as a child welfare worker in Atlanta. At that time, there were many child fatalities. I was very involved in the juvenile court there. I was also very involved as a child welfare social worker in the juvenile justice system in San Francisco where I lived. I have to acknowledge my mentor, a woman named Carol Goss, who is a very prominent child advocate in the state of Michigan. She's the one that convinced me to move in November 2013 to Michigan from San Francisco.

One of the references I want to send to you is the *Raising America's Children* by Larry Adelman from California Newsreel. I am actually featured and interviewed there, so I will send that to you. To be brief, I have two more minutes, I want to tell you my major points and then I will submit them in writing.

I think my recommendations to you—and you have lots to consider, and I will send you more things to consider—one is key to me that this conversation is not preaching to the choir. This conversation is preaching to the converted. Right? We need to focus on our most vulnerable children, those are the youngest children, birth to age 5, within that birth to age 5 range it's birth to one. We know that. Our programs know that. The national data, Michigan's data supports that. What people said earlier: neglect is the gateway, we have to pay more attention, we cannot pooh-pooh neglect.

Secondly, we need comprehensive approaches to support families at risk. And I mean comprehensive. I mean home visiting by the David Olds model or somebody else's model. I mean education programs, which I'm representing HighScope Educational Research Foundation. I think we need social workers. We need a multidisciplinary way of approaching children and families at risk. We need to surround those families, and we have to include the families, even the families that have been adjudicated, no disrespect to the judicial judges here today, who have been adjudicated.

The reality is if you're a psychologist, and I am a psychologist in California, I'm not a licensed psychologist here in Michigan. I'm the ones that have a mental health. Those family members and those communities are responsible for these children and they are responsible for their lifelong health and well-being. We've got to bring them in the room. We can't be others talking about them.

Okay. One more minute. I'm going to suggest a couple of things and I'll send this all to you in writing. The foundation for a successful society is built in childhood. I'm quoting now Jack Shonkoff. Jack is at the Center on the Developing Child at Harvard University. And Jack is now working in Detroit, and we are working with him. You know the healthy development in the earliest years devise the building blocks for educational achievement, economical productivity, responsible citizenship, lifelong health, strong community, and successful parenting for the next generation. We have

data and research. The developmental neuro-science all that brain that suggests that. We can see stress cells, we know the impact and things you've heard today about toxic trauma. What we don't talk about is how do we help balance this. How do we help alleviate these conditions? We can do that with evidence-based practice.

I think the one thing that I want to talk to you about before I shut up, and this is where I come from at this stage of my life, is the role of quality early childhood education and making it a lifelong achievement in children's lives. The small study for that research, which is now 50+ years old, started here in Michigan. In Washtenaw County. A high school, a pare preschool. We know that. Dr. Heckman I saw you had a slide is now doing the latest analysis of that same data. He wrote it in the *New York Times* last month. We're going to meet next week. The same thing. We know this. We are the converted. We've got to do better.

One last thing, and I promise you I'll shut up. We're talking about this. This is too important. When I say comprehensive, this is the piece I want to continue to stress. We are talking about health, we are talking about parenting sessions, we are talking about home visitation, we are talking about educational settings as a hub. Someone was talking about Promise Neighborhoods earlier as protecting children. We have our eyes on these children. We know these families. We know their communities. We have to be ones to embrace these children, and we can do this, and we can and must do better. Thank you for your testimony and allowing me to testify. But I will submit written testimony with stats for you as you can better make your recommendations.

Chairman Sanders: [08:26:29] Thank you. Thank you very much. And thanks to the panel for the last words. They are helpful for us to hear different perspectives and to make sure we are being fully informed. So thank you very much. We have a little time. I know it could be very little time depending on when people's flights are, but I at least want to offer the opportunity for the Commission to have any closing comments and the panel can feel free to go back to your seats. I will also suggest that if there are any questions for Director Corrigan, this might be the time to pose them to her too. Commissioner Covington.

Covington: [08:27:12] Well, you know, this happens almost every time we go to a state because there is so much information to be shared. There are so many people that are doing amazing work, and I always feel really bad in the afternoon. To me we shorten what ends up being just unbelievably powerful presentations. I just want those that presented last to know we will read your materials. We probably will recontact some of you because we are going to want to hear more from you because I think some of those perspectives are so absolutely important. I not only say that because my boss was up here talking about healthy equity. But I think health equity and your lens that you think we need to look at this is so important because we heard all day long that those are the kids that are most at risk, the same kids that are not experiencing equity across our systems. So to me that's going to be something that I hope we focus on. All

I can say once again I think I am a little overwhelmed at all the wonderful recommendations that were presented today. We've got so much work ahead of us in terms of how to frame them and think about them and we just hope we can do justice to all the work that you're doing here in Michigan. Today made me really proud to be among Michigander.

Chairman Sanders: [08:28:21] Commissioner Bevan.

Bevan: [08:28:23] I also want to thank you for your testimony and for being here today. I also want to say that I wish that all of you will take a look at CAPTA. It will be reauthorized. We will play a major role. We need to know what is in there; there is not anything that has been said today that is not already in CAPTA. So, either we change the rules in here or we delete some of the rules. But we have state plan requirements that are being totally ignored, all across this country. So either they don't need to be here or we need to change them, or we need to add something. But we can't ignore CAPTA. We're going to work on it, and I hope that you will really take me seriously. Take a really hard look at the law and let us know what sections need to be changed and where you would like to see, for example, differential response is all the way through this. Should it stay in there? Michigan rejected it. So, do we keep it or not? One of my many questions. But I really implore you to help us out.

Chairman Sanders: [08:29:40] I have a question for Director Corrigan. Thank you for your time today and the question is: different presentations on a variety of very helpful information without question; I noticed that there were not necessarily measures related to reducing child fatalities due to abuse or neglect. Although I know that's been a critical issue that you talked about. And so looking through some of the material, it doesn't jump out that all of the prevention efforts are kind of aligned in moving toward that indicator or necessarily some of the other work that is going on across the state. Is that just the material that was presented? Do you feel there is a plan in place that cuts across the silos that includes prevention that where there is alignment in, we want to reduce child abuse and neglect fatalities?

Corrigan: [08:30:44] I think that the Executive Safety Committee that we have going is really the most directed at that right now. We are looking at that every month and trying to identify initiatives along that score. So I feel that we're there and I think the new initiatives around safe sleep, for example, are specifically directed at reducing fatalities and unsafe sleep practices. One hundred fifty babies dying a year, can we move the needle on that? I believe that we are absolutely focused on the reduction of fatalities.

Martin: [08:31:28] Can I piggy-back on your response?

Corrigan: [08:31:31] Sure.

Martin: [08:31:32] When we talk about safe sleep, and I understand that there are some communities within the United States that advocate safe sleep for bonding with the parents and what have you. I understand that other communities or communities that do encourage this co-sleeping have also started advocating in addition to co-sleeping, ways in which to prevent the fatality. So including putting babies in boxes or putting them in, they're like little sleeping bags that they put between the parents with some boundary, so that there is no rolling over while you're sleeping. So is your Commission advocating not co-sleeping?

Director Corrigan: [08:32:21] I would say that that would be our view is not co-sleeping. We had a campaign in Genesee County: "All alone in a crib of their own" to try to discourage co-sleeping, but there needs to be almost a cultural change on that. I know that there are a fair number of pediatricians—my own daughter-in-law fought me on the subject of co-sleeping with baby. I think there is a cultural change that we need around that area on the safety of co-sleeping. And I think, as you know, while doing this work that many of the overlay deaths are also aggravated by either alcohol, drugs, or other factors that are in there in addition.

Martin: [08:33:11] Thank you. My question was trying to figure out is this organization or this Commission really trying to eliminate or are you trying to help people amend how they do?

Corrigan: [08:33:23] I think eliminating would be fabulous, but I don't think that's realistic. I think that talking about the generations 40 years from now are still going to have deaths from child abuse and neglect. I believe that will occur. How can we reduce the numbers of them? How can we promote safety generally? Get at more prevention what we would call secondary or tertiary prevention in the country to get at some of these broader issues that we've touched on this afternoon.

Chairman Sanders: [08:34:05] Well thank you very much for your remarkable leadership.

Corrigan: [08:34:08] Thank you. It's been my thrill and my privilege to work with this amazing group of colleagues in the department and among private partners in the courts, in the various state departments, and local. You've heard from the stellar folk that we have in the state of Michigan today. So thank you so much for coming to see the work of the great state of Michigan.

Chairman Sanders: [08:34:33] Commissioner Petit I think you had a comment.

Petit: [08:34:36] I think I want to save it for our debriefing tomorrow.

Chairman Sanders: [08:34:42] All right, well thank you. So we'll adjourn the meeting. Thanks everybody. Thanks for those who presented and for those who stayed.

[*Applause*]